Care Quality Commission

Carecall Limited

St Luke's Nursing Home

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

Overall summary

The inspection took place on 6 January 2016 and was unannounced.

St Luke's Nursing Home is registered to provide accommodation for nursing and personal care for up to 32 older people or people living with dementia. There were 29 people living at the service on the day of our inspection. There was also a day centre in the same premises.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have the legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated

The Care Quality Commission is required by law to monitor how a provider applies the Mental Capacity Act, 2005 and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way. This is to protect them. The

Summary of findings

management and staff understood their responsibility and made appropriate referrals for assessment. No one at the time of our inspection had their freedom restricted under a DoLS authorisation. However, the registered provider had made applications to the local authority and was waiting on assessments.

People felt safe and were cared for by kind, caring and compassionate staff. People were kept safe because staff undertook appropriate risk assessments for all aspects of their care and care plans were developed to support people's individual needs. Staff knew what action to take and who to report to if they were concerned about the safety and welfare of the people in their care. People received their prescribed medicine safely from staff that had the skills to do so.

People were cared for by staff that were supported to undertake training to improve their knowledge and skills to perform their roles and responsibilities. People were given a choice of nutritious and home cooked meals. There were plenty of hot and cold drinks and snacks available between meals. People had their healthcare needs identified and were able to access healthcare professionals such as their GP or dentist. Staff knew how to access specialist professional help when needed.

People and their relatives told us that staff were kind and caring and we saw examples of good care practice. People were always treated with dignity and respect and enabled to make decisions about their care and treatment and maintain their independence. People were at the centre of the caring process and staff acknowledged them as unique individuals.

There were systems in place to support people and their relatives to make comments about the service or raise concerns about the care they received. People and their families told us that the registered manager and staff were approachable.

The registered provider had robust systems in place to monitor the quality of the service and make improvements. Staff had access to professional development, supervision and feedback on their performance. The service received recognition from other agencies for areas of good practice.

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 followed correct procedures when administering medicine.

Staff had access to safeguarding policies and procedures and knew how to keep people safe.

Good

Is the service effective?
The service was effective.

People were cared for by staff that had the knowledge and skills to carry out their roles and responsibilities.

People were supported to have enough to eat and drink and have a balanced diet.

Good

Is the service caring?
The service was caring.

Staff had a good relationship with people and treated them with kindness and compassion.

People were treated with dignity and staff members respected their choices, needs and preferences.

Good

Is the service responsive?
The service was responsive.

People's care was person centred and regularly assessed, planned and reviewed to meet their individual care needs.

A complaints policy and procedure was in place and people and their relatives knew how to complain. Complaints were addressed promptly and appropriately.

Good

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

The provider had completed regular quality checks to help ensure that people received appropriate and safe care.

There was an open and positive culture which focussed on people and staff, people and their relatives found the registered manager approachable.

Good

St Luke's Nursing Home

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 6 January 2016 and was unannounced. The inspection team was made up of one inspector.

Before the inspection, the provider completed 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 what improvements they plan to make. We used this information to help plan our inspection.

We also looked at information we held about the provider. This included notifications which are events which happened in the service that the registered provider is required to tell us about.

During our inspection we spoke with the registered manager, the clinical lead, two members of care staff, the cook, two housekeepers, the activity coordinator and seven people who lived at the service and three relatives. We also observed staff interacting with people in communal areas, providing care and support. In addition we spoke with two visiting health professionals.

We looked at a range of records related to the running of and the quality of the service. These included two staff recruitment and induction files, staff training information, meeting minutes and arrangements for managing complaints. We looked at the quality assurance audits that the registered manager and the provider completed. We also looked at care plans for seven people and medicine administration records for eight people.

Good

Is the service safe?

Our findings

People and their relatives told us that they were safe. One person's relative explained why safety was so important to their loved one and said, "He was falling at home; that is why he came here. All the nurses know him and keep him safe and that is all we can ask for."

The provider had policies and procedures in place to support staff to prevent people from avoidable harm, potential abuse and help keep them safe. Staff told us that they had received training on how to keep people safe and how to recognise signs of abuse. Furthermore, staff knew how to share their concerns with their senior managers and the local safeguarding authority. One staff member said, "I would report abuse to the senior carer or nurse in charge." A senior member of care staff told us, "The person might appear scared, they may want to tell you about it. I would report it to my seniors to escalate it, or you can go straight to safeguarding, the number is in the office."

People told us that staff responded when they asked for help. One person said, "Just ring your bell and the carer will come to you." We saw that when people were in their bedroom that their call bell was within their reach. The registered manager ensured that the staff skill mix refected the needs of people in their care. Furthermore, there was a always a registered nurse on duty.

We looked at two staff files and saw that there were robust recruitment processes in place that ensured all necessary safety checks were completed to ensure that a prospective staff member was suitable before they were appointed to post. We found that the same process applied to agency staff. Furthermore, agency staff were provided with a handover checklist to ensure that they were aware of a person's individual routine and complex care needs and emergency contact details.

There were systems in place to support staff when the registered manager was not on duty. Staff had access to an emergency folder that contained contingency plans to be actioned in an emergency situation such as a fire or electrical failure. The village hall had been identified as a short term place of safety and staff at another service registered with the provider had been identified as a "buddy" to support with the evacuation process. Staff had access to on-call senior staff out of hours for support and guidance.

People received their medicine from nursing staff who had received training in medicines management and had been assessed as competent to administer them. One person told us, "The nurses look after my medicine; they give them to me morning and lunchtime." We observed the clinical lead administer breakfast and lunchtime time medicines to people in the dining room. We noted that appropriate safety checks were carried out and the medicine administration records (MAR) charts were completed once the person took their medicine. We saw that the staff member explained to people what their medicine was for and asked people if they required any pain relief. Furthermore, we observed that when a new medicine was received into the service that two members of staff checked the medicine's name and quantity and both signed the MAR chart.

We looked at MAR charts for eight people and found that medicines had been given consistently and there were no gaps in the MAR charts. Each MAR chart had a photograph of the person for identification purposes and any allergies and special instructions were recorded. Where a person did not receive their medicine a standard code was used to identify the reason, such as when a person was in hospital.

We found that where a person managed their own medicine that a risk assessment had been carried out, that they had a care plan to support their independence with taking their medicine and their medicines were stored safely in a locked safe in their bedroom.

All medicines were stored in accordance with legal requirements, such as locked cupboards, medicines trolleys and fridges. There were processes in place for the ordering and supply of people's medicines to ensure they were received in a timely manner and out of date and unwanted medicines were returned promptly. Staff had access to guidance on the safe use of medicines and the medicines policy. All medicine incidents were reported through a formal route and the registered manager investigated them.

Good

Is the service effective?

Our findings

Staff were provided with mandatory training and also, training specific to individual needs, such as administering medicines through a syringe driver. Once staff had completed their induction programme they were expected to complete feedback on how their learning impacted on the standard of care they gave to people. A recently appointed staff member told us that they felt well supported throughout their induction and had received positive feedback from the registered manager. They said, "It helped to build my confidence." We saw that some staff had been nominated as lead person for key topics. For example, one staff member was the link nurse for infection control and attended regular peer group meeting arranged by the local authority. They then supported other staff to maintain safe infection prevention and control practices.

The registered manager had attended the care certificate assessor training and had reviewed the induction training to include the new care certificate. This is a new training scheme supported by the government to give staff the skills needed to care for people.

We observed that people's consent to care and treatment was sought by staff. For example, we saw that people had given their signed consent to have their photograph taken for identification purposes and some had signed consent to reside at the service. A member of care staff said, "Some people have preferences about whether they have care from a male or a female." Staff were aware of how to support a person who lacked capacity to make decisions. One staff member told us, "Even when people lack capacity [to make their own decisions] we still give them choices. If it's a big decision we'll have a best interest meeting and help them to make informed choices. We involve others in this." Where a person lacked capacity to give their consent staff followed the principles of the Mental Capacity Act 2005 (MCA).

The 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.

We saw where a person had lacked capacity to consent to their care that they had appointed a member of their family to act as their Lasting Power of Attorney (LPA). A LPA is someone registered with the Office of the Public Guardian to make decisions on behalf of a person who is unable to do so themselves.

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).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the provider had followed the requirements in the DoLS and several applications had been submitted to the local authority and were waiting for assessments.

The provider had properly trained and prepared their staff in understanding the requirements of the MCA and DoLS. In addition, staff had the support of the clinical lead who was the designated MCA and DoLS lead and trainer for the service.

People were provided with a well-balanced and nutritious diet and offered a choice of meals from a four week menu plan. We found that if a person did not want the choices on offer that alternatives to the menu were available, such as homemade soup. All meals were homemade with fresh ingredients and bought from local suppliers. In addition, hot and cold drinks were provided throughout the day and there were bowls of fruit on the dining room tables and we saw people helped themselves to them. The head cook told us that they did not have a set pudding menu, that staff asked people what they would like and they could had what they "fancied". We saw that homemade cakes and desserts were available.

We saw that there was a board in the kitchen recording people's individual food likes and dislikes. The head cook told us that they catered for people with special dietary needs and also fortified some dishes to support people who may be at risk of weight loss. For example, we found that when needed butter, cream and milk were added to homemade soups and desserts. Furthermore, some people with a reduced appetite were offered extra small meals rather than larger main meals as it supported them to eat

Good

Is the service effective?

more. We looked at food intake charts for people at risk of weight loss and saw that they recorded the amount of food a person was offered and how much they actually ate. Staff were aware when they should take action to address weight loss.

People were asked for their feedback on the quality of their meals and it was mostly positive. People and their relatives told us that they were supported to eat a nutritious and balanced diet, that the food was good and there was plenty of it. One person said, "The food is lovely and you get a choice. I'll have cake and sandwiches at supper. There is always plenty of ice cream, yoghurt and fruit."

One person's relative said, "The food is pretty good, the quality is good." Another person's relative told us that their loved one had lost a significant amount of weight before they moved into the service and said, "They have put on weight since they came in. The food is pureed and fantastic and looks appetising. It is all individual on the plate and home cooked."

People were supported to maintain good health. We saw that people had access to healthcare services such as their GP, dentist and optician. Several people were recently seen by the district nurse for their annual flu jab. Furthermore, people with complex medical problems were supported to attend specialist outpatient appointments. People and their relatives told us that staff responded when they had a health problem. For example, one person's relative said, "They get the doctor when necessary." People had an information sheet with important details such as contact numbers for their next of kin and GP and their likes and dislikes and care preferences. This information went with the person if they were admitted to hospital.

We found good examples where nursing staff had forged strong professional relationships with other health professionals to ensure people received a high standard of healthcare support. For example, we saw that where a person declined nutritional supplements that nursing staff referred them to the dietician for support. In addition, we saw one person had a special plan drawn together with their GP and specialist nurse for emergency medicine to be given when their blood sugar levels were too high or too low.

Good

Is the service caring?

Our findings

We observed staff interacting with people and saw that people and staff had a good relationship and there was lots of friendly banter. People were treated with kindness and compassion by caring staff. We spoke with visiting relatives who informed us that staff were caring. One person's relative said, "Very happy with the level of care. It's the little things. It's a caring organisation. All of them [members of staff] have the same attitude towards care. I would recommend it for long term care."

The care plan structure had recently been revised by the clinical lead. We looked at the care plans for seven people and found that people and their relatives had been involved in their care plans and care was person-centred.

There were measures in place to enable people to be familiar with their surroundings and orientated people to the time of year. For example, there was a wipe clean board in the dining room with the daily weather forecast, the date and the names of staff on duty. Furtheremore, staff were aware that there was a risk that some people could become socially isolated and told us what action they would take to address this. One staff member said, "Most people like to sit and talk to us, but some like their own space, but they can become withdrawn. We tell the manager and we monitor their behaviour and mood."

Some people had difficulty communicating their needs verbally. For example, we observed staff effectively communicate with a person who had been deaf from birth. Staff looked directly at the person and spoke clearly and the person read their lips. Furthermore, we noted that other people were aware of the person's disability and included them in conversations and pastimes.

The provider ensured that people had access to an advocacy service to speak out on their behalf. Advocacy services are independent of the service and local authority and can support people to make and communicate their wishes.

People were enabled to maintain contact with family and friends. One person's relative said, "We can visit anytime. And my niece often visits and brings her dogs in." Relatives told us that their loved ones were treated with dignity and respect. For example, one person's relative said, "The staff are so lovely and friendly. She likes to have her bedroom door open so as she can see everyone when they pass. They all wave to her and some come in and have a chat."

We observed that care and catering staff took a dignified approach at lunchtime. We found that when a person had their meals pureed that all food ingredients were presented separately and their meal looked appetising. We observed a member of care staff assist a person living with dementia who was reluctant to eat their meal. They staff member sat down beside them, supported them to eat their meal at their own pace and treated the person with dignity and respect and acknowledged their achievement.

We saw that people's right to their privacy and personal space was respected. For example, we noted that staff always knocked on a person's bedroom door before entering and doors and curtains were closed when a person was receiving personal care. The housekeepers told us that they always knocked on a person's door before entering and if the person was receiving personal care they would come back later. One house keeper added, "We chat to people as sometimes we are all they see if they are in bed." Some staff told us why it was important to treat people with dignity and respect. One member of care staff said, "Caring is all about listening. Take time with them and treat them as you would like to be treated. Remember, we are in their home and we are respectful to them. People are from different cultures and religions and we have to respect that."

In response to increasing requests to provide care for people near the end of their life the service has introduced several initiatives to support people and their families during this time. For example, a tailored made end of life care plan to enable staff to provide people with a person-centred and dignified death had been introduced. In addition, we saw that when a person was near the end of their life that care staff had worked in partnership with their GP and medicines had been prescribed in anticipation of deterioration in their condition to ensure that they were free from pain and distress. We spoke with a visiting GP who told us that they were very supportive of the new end of life care plan. Furthermore, an information leaflet to support relatives had been introduced called, "Dignity at end of life." The registered manager informed us that it provided families with information on what to do when their relative dies. We spoke with the clinical lead who

Good

Is the service caring?

informed us that the service was registering for the Gold Standards Framework (GSF). The GSF is a national training programme developed to enable nursing and care staff to deliver a gold standard of care for all people in the last years of life.

Good

Is the service responsive?

Our findings

We found that people were encouraged to spend their time how and where they wished. We saw that some people chose to sit in the lounge areas whereas others preferred to return to their bedroom between meals. One person went out for lunch with their family to the local pub. People were supported to maintain their links with the local community. For example, one person attended the local chapel for social events and others regularly attended the day centre that was located in the service

We had a chat with a group of people after lunch. They spoke well of the staff and the standard of care they received. They told us how they liked to spend their time. One person said, "We do different things. On Monday there is a quiz, today a film, dominoes on Wednesday night and sometimes we have bingo with good prizes." Another person said, "A man comes and throws things about. It's good fun and keeps us fit." Two people then excused themselves from the group and returned to their bedrooms. We found that one person was a keen sports fan and was following the cricket season on television and the other person liked to sit in their room to read.

Some people invited us to look at their bedroom. We found they were supported to personalise their bedroom with items from home such as small pieces of furniture, photographs and keepsakes. One person told us that their room had recently been decorated and said, "I've got all new furniture and all my photos and pictures and I can have visitors at any time." A relative told us that they were happy with their loved one's room and said, "Her room is personalised, it looks more like home." Another relative said, "He thinks this is his home. It has nice personal touches." One person, who preferred to spend most of their time in bed, had bird feeders on the fence outside their bedroom window and told us that they like to watch the birds.

We saw that people had care plans tailored to meet their individual needs and people and their relatives were encouraged to take part in reviews of their care plans. We found that relatives had confidence in the care that staff provided. One person's relative told us, "I leave the care plans to staff, but I go to the reviews. We talk about everything and I'm asked if there is anything I think could be better. I feel fully involved." A visiting healthcare professional told us that staff were very willing to support people on short term placements to improve their confidence and independence to return to their own home.

We saw that staff exchanged information about a person's care needs and wellbeing at shift handover to maintain continuity of person centred care. A visiting GP told us that they supported a recently introduced handover sheet as it ensured that information was passed on. Care staff told us that it was important to get to know people, to have conversations with them or their relatives. One staff member said, "If they have pictures in their bedroom, get them to talk about them, they will open up and talk about the people in the pictures and their memories."

We found that people had their care needs assessed before moving into the service. For example, two members of the public asked to speak with us. They were viewing the service to see if it was appropriate for their relative's care needs. They told us that they liked the service and the manager and said, "It's a downstairs room, it's a nice space. The staff are friendly and it looks clean." The manager arranged with them to meet the person in their own home and assess their care needs.

We found that the activity coordinator shared their time between the people who attended the day centre and people who lived in the service. They told us that they spoke with people to find out how they wanted to pass their time and kept a record of their likes and dislikes. We saw that people had recently taken part in events outside the service. For example, five people had visited a local garden centre for lunch and four people had enjoyed a day out at the seaside. Some people enjoyed group events such as a sing-a-long; whereas others preferred quite one to one time for hand manicure or reminiscence.

People, their relatives and members of staff were represented on a small group called the "luxury club". The service received charitable funds through donations and fundraising events and the members of the luxury club met to discuss how they money should be best spent to represent people's preferences. For example, one person liked tropical fish and a fish tank had been purchased for the main lounge.

We found that people and their relatives did not feel the need to attend regular meetings to discuss their experience of the service. Therefore, the registered manager

Good

Is the service responsive?

introduced a quality assurance feedback form and we saw that people who had completed this had responded positively. Furthermore, people told us that if they had any concerns about their care they would tell the registered manager.

The registered manager had received two complaints in the last 12 months and these had been address and resolved in a timely manner. There was also a suggestion box for people and their relatives to give their thoughts on the service. We read four comments and saw that where practical that these comments were responded to and actioned. Some people and their relatives had posted their feedback on the service on a national care home quality assurance website and their comments were all positive.

Good

Is the service well-led?

Our findings

We found examples of practice where strong links had been forged and maintained with the local community to bridge the generation gap. Children from the local Brownie pack and primary school visited the service twice a year to entertain people. In addition, people were kept informed about life in the local community through the parish magazine and a monthly visit from a parish visitor.

Staff told us that they found the registered manager approachable and supportive. One staff member said, "[Registered manager's name] is approachable, has a good impact on the home. She is straight and to the point, but takes time to listen to us." And another staff member said, "Their door is always open."

The registered manager was supported by the provider through weekly visits and daily telephone contact.

Staff worked together as a team and we noted that there was mutual respect between different staff groups. All the staff we spoke with told us that the service was a good place to work.

All staff attended regular team meetings with the registered manager. When asked if they had a voice the head cook said, "Oh crumbs, yes." Another staff member told us, "We discuss everything, food, equipment, training, everyone gets a chance to speak." We looked at the minutes of the staff meeting held in September 2015 and saw that all aspects of life in the service had been discussed. Furthermore, staff were supported through a new programme of supervision and appraisal had been introduced. Responsibilities had been shared with senior staff, such as heads of department and the registered nurses had been delegated with undertaking supervision with care staff.

Staff had access to policies and procedures on a range of topics relevant to their roles. For example, we saw policies on safeguarding and infection control and guidance on delivering personal care. Staff were aware of the whistle blowing policy, knew where to find it and knew how to raise concerns about the care people received with the registered manager.

We found that the registered manager was visible, knew their staff and the people in their care. The people and their relatives that we spoke with knew who the registered manager was and knew them by name. The registered manager undertook random bedroom checks and frequently spoke with people to gather their feedback about their experience of the service.

People and their relatives spoke highly about the registered manager's professionalism and support. For example, one person's relative said, "[Registered manager's name] is an extremely competent person. On looking at the home, she visited [name of relative] at home. We were very impressed, went out of her way. She talked with [name of relative] and put her at ease." Another person's relative told us, "[Registered manager's name] and [clinical lead's name] are very approachable. They are fantastic." We found that people and their relatives did not feel the need to attend meetings to discuss their experience of the service. Therefore, the registered manager introduced a quality assurance feedback form

There was a programme of regular audits that covered key areas such as the kitchen, medicines and infection control. The registered manager told us that the outcome of the quality audits were shared at team meetings and supervision sessions, lessons were learnt and action plans were put in place. We saw evidence of this when an internal medicine audit undertaken in October 2015 identified a discrepancy in stock levels. In addition, an external medicine audit had been undertaken by the dispensing pharmacist on the day before our inspection and identified that the service was now compliant with all aspects of medicine management.

Staff had access to policies and procedures on a range of topics relevant to their roles, For example, we saw policies on medicines, Mental Capacity Act and dignity. Staff were aware of the whistle blowing policy, knew where to find it and knew how to raise concerns about the care people received with the registered manager, local authority and CQC. We found that previous safeguarding and whistleblowing concerns had been investigated by the registered manager and appropriate actions had been taken.