Southmead Rest Home

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Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 29 and 30 December 2016 and the first day was unannounced.

Southmead Rest Home is a care home for up to 16 older people. There were 14 people living there when we visited. Accommodation is provided in bedrooms on the ground and first floors, with the living and dining rooms on the ground floor. Rooms have washbasins and some rooms have an ensuite toilet. The first floor is accessed via a staircase, with a stairlift in place to both wings of the first floor. There is an attractive garden outside with direct access to the small on-site parking area. On street parking is readily available close to the service.

The service has a long-established registered manager, who is also one of the owners of the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service had a homely, friendly atmosphere. There was an established team of regular staff, who knew people well and were caring and kind towards them. Staff were quick to identify and respond when people required assistance, even if people did not communicate this verbally.

People received individualised care that met their needs, including their nutrition and hydration needs; people were positive about the quality of the food. The registered manager and staff reviewed people's care regularly and supported people with their healthcare needs, making referrals as necessary and supporting people to attend appointments. They were mindful of people's preferences for end of life care, ensuring that the necessary support was in place to meet these, particularly if someone's health had deteriorated. The service had within the past year been reaccredited with the Gold Standards Framework in end of life care, with very positive feedback from the external assessor. The registered manager recognised that this process had improved the quality of care overall, as well as the way the staff team communicated with each other and with healthcare professionals.

Where people had the capacity to consent to their care, their consent was obtained. Where people did not have the capacity to consent to particular aspects of their care, staff followed the requirements of the Mental Capacity Act 2005. Mental capacity assessments and best interests decisions had been recorded where necessary, in relation to particular aspects of people's care where there were concerns about their ability to give consent. We have made a recommendation regarding developing the confidence of staff to record mental capacity assessments and best interests decisions.

The registered manager understood where the law considered people to have been deprived of their liberty and had applied for deprivations of liberty to be authorised under the Deprivation of Liberty Safeguards.

People felt safe at the service. Risks to their health and wellbeing were assessed and managed. The premises and equipment were maintained in good order. Staff were aware of their responsibilities for reporting accidents, incidents and concerns, including safeguarding adults. Safeguarding adults information, including contact numbers for local statutory agencies concerned with safeguarding adults, was displayed in the hall. Medicines were stored and managed safely and people received their medicines when they needed them. However, instructions for administering topical medicines, such as skin creams, and medicines to be taken as necessary rather than regularly were not always clearly recorded. We have made a recommendation concerning this.

Staff received the training, development and support they needed in order to be able to perform their roles effectively. There were sufficient staff on duty to meet people's care needs; staff confirmed the registered manager stepped in to cover shortfalls if necessary. Checks such as references and criminal records checks were undertaken to ensure that new staff were suitable to work at the service.

People, their relatives and staff had confidence in the management of the service and their views were sought and used to develop and improve the service. Staff morale was good. The registered manager had close oversight of the service and undertook regular audits, including medicines and health and safety.

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.

Staff understood their responsibilities in relation to safeguarding adults and knew how to report concerns.

People's risks were individually assessed and monitored and action was taken to help keep them safe.

Medicines were stored and managed safely.

Is the service effective?

Good

The service was effective.

People received care from staff who were supported to develop the skills and knowledge they needed to perform their roles effectively.

Staff understood people's health needs and made prompt referrals to health care professionals when needed.

People's nutrition and hydration needs were met. They were positive about the quality of the food.

Is the service caring?

Good

The service was caring.

Staff consistently treated people with dignity, respect and kindness.

People received care and support from a regular team of staff who knew them well and understood how they liked their care to be delivered.

People were supported to set out their preferences for end of life care. Staff knew their wishes and how to make sure that people had dignity, comfort and respect at the end of their life.

Is the service responsive?

Good

The service was responsive.

People received consistent, personalised care that met their needs. Their care needs were set out in care plans that were regularly reviewed and kept up to date.

People were protected from the risk of loneliness and boredom. Professional visitors to the service delivered some group activity sessions. People were encouraged to maintain individual interests.

There was a range of ways for people and their relatives to raise any issues or concerns. The service had a complaints policy and procedure, although there had been no formal complaints in the past year.

Is the service well-led?

Good

The service was well led.

People, their relatives and staff were meaningfully involved in maintaining and improving the quality of the service. Their views were sought and listened to by the registered manager and the other owner.

The registered manager worked closely with staff, which gave them insight into the standard of care provided. Staff morale was good and staff were confident in the way the service was managed.

Southmead Rest 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 29 and 30 December 2016 and the first day was unannounced. It was undertaken by an adult social care inspector and an expert by experience on the first day, and the inspector returned alone on the second day. An expert-by-experience is a person who has personal experience of using or caring for someone who uses services, in this case for older people.

Prior to the inspection we reviewed the information we held about the service, including statutory notifications of serious incidents such as deaths and serious injuries and the 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.

During the inspection we met everyone who lived at the service, except for one person, and spoke with seven of them. We also spoke with two relatives, a professional visitor, three members of care staff, the chef, the registered manager and the other owner. In addition, we made general observations, including watching the delivery of care in communal areas. We viewed two people's care records, everyone's medicine administration records, three staff files, staff rotas for the past month and other records relating to the management of the service.

Good

Is the service safe?

Our findings

People told us they felt safe living at the home. For example, a person commented, "I am very happy here. I feel very safe here" and someone else told us, "I feel very safe here. The staff are very good".

Peoples' medicines were managed and administered safely. A person commented, "Medication is administered to me every day". Medicines were stored securely and records kept and checks made to ensure stocks of medicines were sufficient and all accounted for. Periodically the pharmacy audited medicines management at the service and action had been taken to address any matters highlighted, such as obtaining an up-to-date copy of the British National Formulary (which lists purposes, doses, side effects and contraindications of medicines available in the UK). People's pain levels were routinely assessed, and where people had difficulty communicating verbally staff used a recognised pain assessment tool.

Some people had topical medicines prescribed for skin conditions such as creams and lotions for dry skin. Staff recorded on charts for each cream when they had applied it. However, the way the charts were designed made it difficult to see at a glance whether the prescribed number of doses had been applied each day. Additionally, the cream charts did not all give clear instructions about how creams should be applied. In practice, the registered manager and staff knew why and how particular creams were administered for each person. The registered manager confirmed there were no wounds arising from skin conditions and said they would review the recording of topical medicines including creams.

Some people had medicines prescribed to be used PRN, or as required. The registered manager and staff who handled medicines understood what these were for and how and when they were to be used. However, not all PRN medicines had a clear written plan that set out their purpose, maximum dose in 24 hours and minimum interval between doses.

We recommend the service reviews its recording of topical and PRN medicines, to help ensure these continue to be used as prescribed, for example if temporary staff need to administer medicines.

People were protected against the risks of abuse. Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. They had training in safeguarding adults. Information about safeguarding adults, including how to report concerns to the local authority or police, was clearly displayed in the hallway.

Risks to people's personal safety had been assessed and plans were in place to minimise these risks. These supported people to be as independent as possible and were reviewed and updated each month. Risk assessments and management plans covered areas such as falls, malnutrition, moving and handling, and the development of pressure sores. They also addressed risks that were particular to the individual, such as the risk of choking. Where people slept on pressure-relieving air mattresses, staff recorded daily checks confirming the mattresses were set correctly according to the person's weight and were operating properly. Where people needed to be lifted and transferred using a hoist, there was a notice in their bedrooms next to their individual slings reminding staff of their responsibility for visual checks that the hoist and slings were in

good order on each occasion they used them. Where people needed bed rails to reduce the risk of falling from bed, a risk assessment had considered the suitability of using bed rails with them.

People were protected against hazards such as falls, slips and trips. When people had accidents or incidents these were recorded and checked by the registered manager to identify any actions that were needed immediately and monitored monthly to look for developing trends. People had Personal Emergency Evacuation Plans that set out the assistance they would need to remain safe in an emergency, such as a fire, that might require the building to be evacuated. The premises were clean and well maintained, and staff reported that the owners attended quickly to any breakages or repairs. Investment in the upkeep of the service was viewed as an ongoing priority. For example, a new call bell system had recently been installed and a new fire detection and alarm system panel had been purchased within the past couple of years. Current certification was in place for gas and electrical safety, checks on lifting equipment, the water supply being free from legionella bacteria, and the inspection and servicing of fire safety equipment.

People were supported by sufficient staff with the right skills and knowledge to meet their individual needs. People told us there were sufficient staff to meet their needs and that staff were on hand to provide assistance when they needed it. Staff confirmed they were able to meet their responsibilities within existing staffing levels. The registered manager explained that people's dependency levels were constantly monitored to ensure staffing levels were sufficient to meet their needs. During the day there were three or four care staff on duty in the morning and two in the afternoon and evening. At night there was one waking member of staff on duty, with the owners who lived on site available to provide support if necessary. When they were away, there were two waking members of staff. No-one living at the home routinely required assistance from two staff during the night. A member of staff commented, "If we're short, [registered manager] steps in to help".

Safe recruitment practices were followed before new staff were employed to work with people. Checks were made to ensure staff were of good character and suitable for their role. Criminal records checks were made with the Disclosure and Barring Service and references were obtained, including from past employers. Confirmation was obtained that staff members were entitled to work in the UK.

Good

Is the service effective?

Our findings

People and their relatives spoke positively about staff and told us they were skilled to meet their needs. For example, a person commented, "Very good staff here. The food is good. [Chef's name] is a good cook", and someone else told us emphatically that they were "more than" happy and the staff were "perfect".

People received care from staff who had the skills, knowledge and understanding needed to carry out their roles. Staff confirmed they had access to the training they needed and that they were supported to work towards qualifications appropriate to their role. A member of staff who started in role as a care worker during the past year had attained the Care Certificate, which is a nationally-recognised qualification for staff new to working in care. Staff were also encouraged to work towards diploma qualifications in health and social care. Training was provided through classroom and practical sessions by an external trainer in certain subjects such as annual moving and handling updates. Other training was provided in house using a distance learning package. Training covered topics such as food hygiene, infection control, health and safety, the Mental Capacity Act 2005 and safeguarding. Staff who administered medicine had training in the safe handling of medicines and the registered manager assessed their competence in handling medicines each year.

Staff told us they had been well supported by the owners, including the registered manager. They said the owners readily made time to talk with them if they needed this. They had an annual appraisal, which considered their training and development needs, with a follow up appraisal mid-way through the year. However, staff said they could approach the registered manager at any time if they had concerns or queries about aspects of their work.

People or their legal representatives were involved in care planning and their consent was sought, where they were able to give this, to confirm they agreed with the care and support provided. This included the administration of medicines and the use of bed rails.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The 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.

People's rights were protected because the staff acted in accordance with the MCA. Wherever possible, people were able to make choices about their care and these were respected. The registered manager

ensured where someone lacked capacity to consent to particular aspects of their care, a best interest assessment was carried out. For example, there were concerns that one person did not understand the implications of consenting to care and to taking medicines. Mental capacity assessments and best interests decisions had been undertaken in relation to these areas. However, the wording of one of the mental capacity assessments indicated that although staff may understand how the MCA works in practice, they were less confident with recording this in writing.

We recommend the service reviews how staff record mental capacity assessments and best interest decisions and supports them to become more confident with this.

The registered manager understood how to identify that someone might be deprived of their liberty and that deprivations of liberty needed to be authorised in law. They had made DoLS applications to the relevant supervisory body. One person's deprivation of liberty had already been authorised under DoLS and the service had applied for this to be renewed prior to the expiry of the original authorisation.

People told us they liked the food. Comments included, "The food is very nice and there is a menu", "The food is very good. I like it", "The food is nice here" and "The food is good and they will make me anything that I want to eat". Meals were attractively presented and well received. People's dietary needs and preferences were documented and known by the chef, registered manager and staff. The chef kept a record of people's needs, likes and dislikes. The menu was displayed in the dining room and people could request an alternative if they did not want the main menu item. The chef conducted an annual survey about people's satisfaction with the food, and regularly spoke with people informally to find out how they felt about the food and discuss ideas they would like to try. The chef had designed four-week rolling winter and summer menus with an emphasis on seasonal produce and trying where possible to use local suppliers.

People received the support they needed to eat their meals. Staff were attentive and helpful during mealtimes. For example, we saw a member of care staff take time to explain to someone who was visually impaired what was on their plate and where it was. One person preferred to sit in the living room to eat and staff checked on them regularly.

People's weight was monitored and where there were concerns about unplanned weight loss, the GP consulted with a view to seeking a referral to a dietician. Similarly, referrals to a speech and language therapist were sought if there were concerns about their ability to swallow food without choking.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals. People had access to a GP, dentist and an optician and could attend appointments when required, with support from the registered manager if necessary.

Good

Is the service caring?

Our findings

People told us the staff were caring. Comments included "The carers are very nice to me" and "The carers are very good to me". One person was not able to tell us about their experience. We observed this person was at times agitated, but staff anticipated and responded to their needs and the person soon became calm. This illustrated the attentiveness and understanding of staff towards them. For example, the person had become distressed and staff had identified that they would like to see their flowers; the person was instantly quieter and happier when their flowers were placed in front of them.

People were treated with kindness and compassion in their day-to-day care. All of the interactions we observed between staff and people living at the service demonstrated dignity and respect. Staff showed concern for people's wellbeing in a caring and meaningful way, and they responded to their needs quickly, whether answering call bells and other requests for help or spotting that someone needed assistance. They did not rush people while supporting them. Where people needed assistance with aspects of personal care, staff offered this discreetly. All personal care took place in private.

People received care and support from staff who had got to know them well and who understood and respected their preferences. There was a small, regular staff team. Staff knew people's abilities and preferences and understood how people communicated, even where their verbal communication was limited. People's records included information about their life history and their preferences regarding their support, gathered from the person and their relatives on and after admission. Although people were encouraged to spend time in communal areas, staff respected some people's preference to spend time on their own or not to join in activities. For example, one person particularly liked to be outside even in cold weather, and cushions and blankets had been provided so they could sit in comfort on a sunny bench in the garden. People were encouraged to personalise their bedrooms with personal objects and pictures.

People were given the information and explanations they need, at the time they need them. Staff explained to people what they were doing, for example reassuring people and keeping them informed of their actions while they were using moving and handling equipment. Information about advocacy services was available in communal areas of the building and via the service's website.

The service had within the past year been re-accredited with the Gold Standard Framework for end of life care (GSF). This is a nationally-recognised quality initiative in relation to end of life care. People and their relatives were supported to set out their preferences in relation to end of life care, including whether they wished to be taken to hospital due to frailty associated with old age and who they wished to be with them in their final hours. These formed the basis of advance care plans, which would come into effect when people were no longer able to communicate their wishes and preferences. These were reviewed annually, and would also be reviewed if someone wished to change their decisions. The people whose files we reviewed wished to die at the service rather than in hospital and 'Do Not Attempt Cardio-pulmonary Resuscitation' notices had been provided by their GPs following consultation with each person, their representatives, and the registered manager. The service had informed the local ambulance service of these to help ensure that people were not admitted to hospital for reasons other than acute injuries. Staff had been trained about

dying and bereavement, and information about the GSF was given to all new staff. Monthly GSF status reviews considered how close each person was to the end of their life and any actions that were needed accordingly, such as involving the GP and district nurses to prescribe and administer end of life medicines.

Good

Is the service responsive?

Our findings

People and their relatives were positive about the quality of care people received. Comments included, "I am happy with this home" and, "This is a great place and [name] is really well cared for. The staff are very good indeed".

People and, where they wished, their relatives were involved in developing their care, support and treatment plans. People had their needs assessed before they moved in to ensure the service would be able to meet their needs safely. Information had been sought from the person, their relatives and other professionals involved in their care. This had informed the plan of care. Once they moved in, people's needs were reviewed at least monthly and updated as needed.

Care plans were personalised according to people's individual needs and choices. They covered support needed with activities of daily living such as maintaining a safe environment, communicating, mobilising, eating and drinking, pressure area care, and sleeping and night time needs. Where more detail was required, such as where people needed to use moving and handling equipment, this was recorded. Speaking with the registered manager and staff, they were able to explain the care people needed. We observed that people received care in line with their care plans whilst they were in communal areas, such as support to mobilise. People were clean and neatly presented, indicating that they had received any support they needed with personal care, including attending to their hair and make-up. A person told us that someone came regularly to cut people's toenails.

Handover between staff at the start of each shift ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored.

Group activities were organised to provide entertainment and stimulation. A person living at the service told us, "We have nice entertainers visit, singers and piano players. We also have games and things". Someone else said, "A nice boy comes in and sings… he's got a violin, he plays music". During the inspection, someone came to deliver a keep fit session with exercises that people could do in their armchairs. People and staff told us that other staff visited from time to time to perform music or do manicures. We also saw care staff delivering a quiz. A person spoke with the staff afterwards saying that they did not really enjoy quizzes and would prefer bingo. The staff acknowledged this and explained sensitively how bingo would not have been suitable for other people, for example due to visual impairments.

People were also supported to keep themselves occupied and to maintain links with the local community. For example, someone told us, "I get taken out by [registered manager]. She is very helpful". Most people had newspapers or magazines delivered in the morning. One person liked to do jigsaws and had a table in their bedroom that was dedicated to this. They explained how staff took them to the library to borrow jigsaws. Another person continued to attend their church.

Complaints and concerns were viewed as an opportunity to improve the service. However, there had been no complaints in the past year. People told us they would feel able to approach the manager if they had any

concerns about their care. The service had a complaints policy. This was updated during the inspection to reflect how people could direct their complaints if they were unhappy with the service's response, acknowledging that CQC does not have powers to investigate individual complaints.

Good

Is the service well-led?

Our findings

The service had a positive, open, person-centred culture. People and staff commented on the friendly, family feel of the service. For example, staff told us they were very happy working at the service, saying, "It's like a family here" and "We all work hard together". They talked about teamwork with experienced colleagues who were "really good" at supporting them when they asked questions. They said they felt valued and supported by the registered manager and owner of the service; comments included "[The owners] do look after me". There had been little turnover of staff prior to the retirement of three long term members of staff earlier in the year.

People and staff had confidence the registered manager would listen to their concerns, which would be received openly and dealt with appropriately.

People and those important to them had opportunities to feed back their views about the home and quality of the service they received. People told us they saw the registered manager; for example, we were told, "The manager speaks to me regularly", "I sometimes talk to [name] the manager", I speak with [registered manager's name] quite a lot" and "She's very approachable". Quality assurance surveys were undertaken every 18 months. Recently returned questionnaires from residents, relatives and other regular visitors were in the main positive about all aspects of the service, including the quality of care. In respect of the few suggested improvements, the owners were already aware of the limitations and the reasons why further action was not practicable. In addition, residents' meetings took place from time to time. Two residents' meetings were recorded in 2016, at which people had discussed their views and wishes about various aspects of the service, from decorating the Christmas tree to plans for trips out.

Staff were involved in the development of the service. There were monthly Gold Standard Framework (GSF) meetings, to which all staff including the chef and cleaners were invited. These reviewed people's care and planned any actions needed in relation to people's end of life care. The times and days of these meetings were varied to enable as many staff as possible to attend at least some of the meetings. Staff had also been involved in developing the template for the service's end of life care plans, by completing a questionnaire about what they thought would be important to people at the end of life. Staff meetings to discuss more general matters affecting staff took place a couple of times a year.

Quality assurance systems were in place to monitor the quality of service being delivered. The registered manager and the other owner of the service spent much of their time at the service, the registered manager frequently working alongside staff. This gave them an insight into how the service was operating. The process of GSF reaccreditation had required the registered manager to assess and reflect on how the service was performing. The registered manager said the involvement of everyone at the service in this process had raised the standard of care, improved communication within the service and with GPs. The external assessors had been complimentary about the revalidation, remarking on the 'excellent portfolio of evidence… clearly demonstrating that the GSF has been embedded as standard practice within the home' and scoring the service very highly, at 48 out of 50. The registered manager oversaw regular audits of medicines and health and safety, which included fire safety.

The registered manager and other owner were actively involved in local and national organisations concerned with residential care. They attended conferences and professional development days to help them stay abreast of changes in legislation affecting care services and developments in good practice.

The registered manager had notified CQC about significant events such as deaths and serious injuries. We use this information to monitor the service and ensure they respond appropriately to keep people safe.