Sanctuary Care (Wellcare) Limited

Simonsfield Residential Care 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

Summary of findings

Overall summary

Simonsfield Residential Care Home provides care and accommodation for 36 older people, some of whom were living with dementia. Accommodation is provided in single bedrooms situated on three floors. At the time of our inspection, there were 36 people living in the home.

At the last inspection on the 16 November 2015, the service was rated Good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. The service was meeting all relevant fundamental standards. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

Medication was recorded accurately and stored securely. Staff received training and regular competency checks to ensure safe administration.

Risk assessments were completed to consider any potential risk to people and accompanying support plans were evaluated regularly. Procedures were in place to monitor and analyse accidents and incidents for future learning and prevention.

Staffing numbers were maintained at a suitable level to support people in a timely manner according to their needs as assessed through a dependency tool. Some people told us they thought the service would benefit from more staff and we raised this with the registered manager at the time of our inspection.

The registered manager had systems and processes in place to ensure that staff who worked at the service were recruited safely. Staff had received training in 'Safeguarding' to enable them to act if they felt anyone was at risk of harm or abuse and understood the reporting procedures.

Everyone we spoke with felt staff were competent. Staff received relevant training to equip them with the skills and knowledge to complete their job role effectively. Staff felt well supported with their learning and development and felt they could raise any issues both formally and informally.

We spoke to two health professionals during our site visit who spoke positively about the care offered at the home. One visiting health professional approached us to commend staff on their intervention with one person whose well-being had markedly improved since being admitted to the home.

Most people we spoke with were happy with the food served at the home and a variety of drinks was served throughout the day to ensure their hydration needs were met. The dining experience was pleasurable with beautifully laid tables and background music.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were complimentary about staff and told us that staff treated them with dignity and respect. Comments included, "The staff are marvellous" and "They're always polite and courteous, they treat me very well." We observed a variety of kind and caring interactions between staff and people who lived at the home. People told us they could have a laugh with staff and this was evident during our inspection.

Care was planned and delivered in way that responded to people's assessed needs. Care plans contained important information on people's personal preferences and monthly evaluations were completed to ensure the service remained responsive to people's evolving needs.

People enjoyed a range of activities, including days out in the local community using the service's minibus and theatre trips. The activities co-ordinators catered the activity programme to meet people's individual preferences and people spoke positively about them. One person commented, "The activities co-ordinator is very good, I like the activities."

The registered manager had been employed at the home for over 10 years and maintained an active and visible presence at the service. People told us they were approachable and dealt with problems quickly. One commented, "She's brilliant, everyone loves her. I could talk to her without a doubt. She'll say, 'I'll have a look right now' and gets things sorted." Staff also echoed this positive feedback. One commented, "[Registered manager] gets stuck in, they aren't scared to get their hands dirty, they interact with residents, they are fantastic."

Opportunities were available for people and their relatives to provide feedback and contribute to service delivery through the use of quality assurance surveys and regular 'resident and relative' meetings.

There was a series of audit systems and processes to monitor the quality of the care and improve service delivery. These included a variety of self-assessment tools and an electronic reporting system to ensure managerial oversight of areas such as care plans, medication, accident and incidents and untoward events.

The registered manager had notified the Care Quality Commission (CQC) of events and incidents that occurred in the home in accordance with our statutory requirements.

Further information is in the detailed findings below.

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 remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Simonsfield Residential Care 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.

This inspection took place on 4 July 2018 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, in this case, caring for a person living with dementia.

Prior to the inspection we contacted the local authority quality monitoring team to seek their views about the service. We were not made aware of any concerns about the care and support people received. We checked to see whether a Health Watch visit had taken place. Health Watch is an independent consumer champion created to gather and represent the views of the public. They have powers to enter registered services and comment on the quality of the care. They told us their last visit to the service was positive.

Before the inspection, we asked the registered provider to complete a Provider Information Return (PIR). This is a form that we require providers to send us at least annually to give some key information about the service, what the service does well and improvements they plan to make. We also considered information we held about the service, such as notification of events and incidents which occurred at the service which the registered provider is required by law to send to CQC. We used all this information to plan how the inspection should be conducted.

As part of the inspection, we spoke with the registered manager, deputy manager and three members of care staff. We spoke with 11 people who used the service and one relative. We spoke to a domestic

supervisor, the activities co-ordinator, the chef and two visiting health professionals. We reviewed care plans for four people who used the service, three staff personnel files, Medicines Administration Records (MAR) for five people, staff training and development records as well as information about the quality assurance and management of the service.

We observed the lunchtime service and staff interaction with people who lived at the home at various points during the inspection. We carried out a Short Observational Framework for Inspection (SOFI). SOFI is a methodology we use to support us in understanding the experiences of people who are unable to provide feedback due to their cognitive or communication impairments.

Good

Is the service safe?

Our findings

Everyone we spoke with told us they felt safe living at the home. People provided a variety of comments when asked what makes them feel this way. Comments included; "The security of the home", "I love it, all of it. They all think a lot of me" and "The fact the staff are here, if there's anything you want you've just got to ask the staff." A visitor told us, "I like it because [relative's] safe, this home's fantastic."

Our review of staff rotas and the registered manager's dependency tool showed staffing levels were sufficient for support to be provided in an effective manner. Some people told us staff could be rushed and the home could benefit with more staff, however, response times were good and their call bells were generally answered promptly. We raised this with the registered manager at the time of our inspection who told us they had no staff vacancies at present but they would continue to review dependency levels within the home and the deployment of staff in light of our feedback.

Safe recruitment processes were followed and all personnel files contained the relevant pre-employment recruitment checks to show staff were suitable to work in a care environment, including Disclosure and Barring Service (DBS) checks. Staff had received training in safeguarding and were able to explain the course of action that they would take if they felt someone was being harmed or abused.

Medication was safely managed and administered by staff who had received the relevant training. We reviewed the Medication Administration Records (MAR) for five people and saw that they were completed accurately. We checked a sample of medications and controlled drugs and found that the balances of the stock corresponded to what was recorded on the MAR chart. Medication was stored securely and within the appropriate temperature ranges.

Assessments and accompanying support plans had been completed for areas such as falls, moving and handling, continence, bed rails, eating and drinking, and pressure ulcers to protect people from the risk of harm. Action was taken to minimise the risk of harm, for example, one person at risk of skin breakdown had a profile bed, airflow cushion and repositioning support at night. The daily records showed support was delivered in accordance with this risk management plan.

The registered manager maintained a log of all accidents and incidents and these were reviewed and analysed to prevent the risk of re-occurrence. These were logged on the electronic system and discussed within governance meetings to ensure oversight at registered provider level.

The building itself was clean, well-maintained and free from hazards. A series of risk assessments and checks were carried out to ensure that the environment did not pose a risk to people living in the home including equipment maintenance and utilities checks. Fire procedures in the event of an evacuation were clearly marked out and people had Personal Emergency Evacuation Plans (PEEPs). Staff had received training in first aid, fire safety and infection control. Daily, weekly and monthly cleaning tasks were undertaken to promote a hygienic environment. Everyone we spoke with told us the home was clean and the domestic staff were visible throughout the day.

Good

Is the service effective?

Our findings

Staff received training in subjects such as dementia, dignity and moving and handling to ensure they had the skills and knowledge to carry out their roles effectively. The registered provider's training and supervision matrix showed that staff training was up to date and staff had access to supervision six times a year. People told us that staff were competent and had the skills and knowledge to support them. Comments included, "They seem fine to me, I've no complaints" and "Yes, they're there for me."

Staff had received training in the Mental Capacity Act (MCA) 2005 and understood the principles within the Act. Care files included mental capacity assessments and demonstrated that people were encouraged to make decisions if able to. Consent documents were contained within care files and covered specific decisions such as photography, information sharing and agreement to the plan of care. These were signed by people themselves if able. People's lasting power of attorneys were recorded in care files.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager maintained a log of DoLS authorisations and pending applications. One person's authorisation contained a condition for staff to encourage the person to use their hearing aids and we saw this was clearly reflected throughout the care records. Best interest meetings were held if people were deemed to lack capacity for decisions, such as their placement at the care home.

People were supported to access health professionals with regular check-ups to maintain their health and well-being. Staff accompanied people to appointments and records showed that staff had sought professional input, for example, medication review requests. We spoke to two visiting health professionals during our inspection who provided positive feedback regarding staff and the care provided at the home. One told us that staff were 'vigilant' in identifying a deterioration in health and alerted them to any concerns without delay.

People were supported by staff to have their nutritional and hydration needs met. Dietary assessments were completed and people's preferred food and drinks were documented within care files. The chef was aware of any additional support requirements, such as pureed diets and nut allergies. Most people were satisfied with the food served at the home. Comments included, "It's lovely", "I think it's fair, I'll have a go at whatever they give me", "It's good, you wouldn't get better anywhere else" and "Pretty good considering the number of people." We observed the lunchtime service and noted that it was a pleasant experience with background music and tables were laid with tablecloths, napkins and flowers.

The environment of the home was clutter free and accessible for those with mobility problems. The home had adapted some bathrooms for those with mobility difficulties and further refurbishment works were planned on the rest. A range of pictures and posters of a past era were displayed in the dining room and throughout the building to promote people's thoughts and memories. Bedrooms were homely and cosy and people had input into their decoration and could bring their personal furniture with them.

Good

Is the service caring?

Our findings

We observed warm and genuine interactions between staff and people who lived at the home and people were complimentary about the staff. Comments included; "I think they're lovely, we have a laugh", "Lovely, I wouldn't do without them", "[Staff are] wonderful, you're never without a friend" and "Very good they are, we are human and we laugh and joke." Everyone told us they were treated with dignity and respect.

Staff understood the importance of preserving privacy and ensuring dignity whilst attending to people's personal care needs. People told us staff always knocked before entering their bedrooms and doors and curtains were closed during personal care tasks. A dignity information board and 'Liverpool's Dignity in Care Charter' was on display in the communal area of the home as a sign of the service's commitment to delivering a high-quality service that respects people's dignity, rights and choices.

Staff encouraged people to remain independent and understood the importance of this. This emphasis on empowerment was also reflected within care records. For example, support plans in respect of personal care considered what the person could do for themselves and the skills and abilities they retained, such as to wash and dress themselves. Another care file documented that whilst the person lacked capacity, they were still able to indicate their needs and needed to remain empowered to be involved in decision-making.

Not everyone could recall being involved in discussions about their care but it was evident through our review of records, that people, and their relatives had been consulted. Regular support plan evaluation meetings were held which showed that staff had involved people in decision-making and asked for their input into the planning of their care. Some people had signed to confirm that they did not want to be involved in this process but were happy for staff to undertake this on their behalf. We observed the registered manager asking for consent from one person to have a medical sample taken with an explanation of why this was needed to ensure the person was fully informed.

The advertisement of local advocacy services in the communal area of the home ensured people could access support if required. Advocates help to ensure that people's views and preferences are heard.

People's communication needs and any barriers to communication were clearly recorded in files within communication assessments and support plans. This ensured that people who might need additional support were identified. For example, one person had a hearing impairment. Care files instructed staff to provide additional support during board games and outlined any additional support aids required to ensure information was accessible to them. Another care file outlined that the person preferred to be spoken to on the left side due to a hearing impairment.

Good

Is the service responsive?

Our findings

We spoke to the activities coordinator and people who used the service who told us that the service facilitated access to a range of activities to promote social stimulation and interaction. Activities included; quizzes, poetry afternoons, arts and crafts, baking, chit-chat club, reminiscence and gardening. People told us they enjoyed the events that were arranged within the home and trips out using the home's minibus to local parks and theatres. Comments included, "I like to listen to classical music and I like the quizzes", "I like the quizzes and the things the activities coordinator does", "I go on the minibus, I like the parks" and "I like going on the trips, the activity coordinator is wonderful." A visitor told us, "[Relative] has been to the garden centre, parks and for afternoon tea."

Care plans were in place regarding all aspects of care including; personal care, communication, oral hygiene, nutrition and mobility and were evaluated monthly to ensure the service remained responsive to the person's needs. A personal profile entitled 'This is Me' provided staff with information on people's social background and life story to enable them to get to know the person they supported. People's preferences and daily routines were recorded in 'My Day' document to enable staff to deliver a person-centred service.

People had access to a complaints policy which was on display in the communal area of the home. People told us they would speak to staff or go to the office to speak to the manager if they wanted to complain. Comments included, "[I would go to] the boss, she's lovely" and "Yes [I know how to complain] but there's nothing wrong." The last formal complaint was received in November 2017. We reviewed a selection of formal complaints and saw that concerns were responded to appropriately and in accordance with the registered provider's policy.

The staff training matrix showed that care staff had received training in 'end of life care'. The registered manager advised us they would strive to ensure people could remain at the care home at the end of their lives if that was in line with their wishes. The registered manager kept a record of people who had completed 'Do Not Attempt Resuscitation' (DNAR) forms. People were asked about their end of life wishes and care records contained documents outlining people's preferred arrangements if they chose to share these.

Good

Is the service well-led?

Our findings

A registered manager was in post and had been employed at the service for over 10 years. 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 registered manager was a visible presence in the home and we observed people approaching them with ease and familiarity during our inspection to ask for assistance or to have a chat. People's comments included; "She's very good. I'm very happy with the way things are, I wouldn't do without them", "She's very friendly" and "I'd ask her anything."

The registered provider had changed in 2018 and the registered manager told us that staff and the management team had adjusted to new recording systems, processes and documentation. Staff told us they enjoyed working at the home and felt well supported by the management team. Staff comments included, "[Registered manager] really knows her job, they are an excellent manager", and "[Registered manager] is good, the deputy manager is also excellent." Staff meetings were held regularly and discussion was held regarding resident's needs, scheduled training and supervision.

A range of quality assurance systems were in place to ensure monitor and improve the quality of care being delivered. This was facilitated through a new electronic audit system named which promoted managerial oversight in areas such as untoward events, falls, injuries and medication errors. The registered manager told us they found this system very effective in enabling them to monitor and retain oversight of incidents within the home. Any issues highlighted, such as outstanding documentation, had action plans formulated along with a timescale and these were marked off by the regional manager once completed. This two-tier quality assurance system meant that processes to monitor the quality of care were robust.

Regular audits were completed in respect of staff personnel files, health and safety, care plans and medication. The registered manager also completed a monthly quality checklist and reports were compiled by the registered provider monthly. A series of meetings were held on a regular basis including health and safety, and governance meetings whereby complaints, accident and incidents, recurrent falls and any untoward events were reviewed and any trends were considered.

Opportunities were available for people to comment on their experience of the care delivered through regular surveys and 'resident and relative' meetings. Minutes showed discussion was held regarding topics such as activities, food and events. Action plans were devised and these were discussed as an agenda item at each meeting. Survey results were summarised and feedback was presented to people via a 'You Said, We Did' display which was visible in the communal area of the home. We reviewed a selection of survey responses and saw that people were positive about the care they received. Comments included, "Staff are friendly and helpful. You can have a laugh. They are super."

The service worked in partnership with other organisations to make sure they were following current practice and providing effective care. These included social services and healthcare professionals, two of

whom provided positive feedback during our inspection site visit.

The registered manager was aware of their roles and responsibilities and had reported all notifiable incidents to the Care Quality Commission as required. The ratings from the last inspection were clearly displayed in the home.