Castlegate House Rest Home Limited

Castlegate House Residential Home

Inspection report

49 Castlegate
Grantham
Lincolnshire
NG31 6SN

Tel: 01476560800

Date of inspection visit:
10 January 2019

Date of publication:
21 January 2019

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 10 January 2019 and was unannounced.

Castlegate House is a care home that provides accommodation and personal care for a maximum of 20 older people including people who live with dementia or a dementia related condition. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission regulates both the premises and the care provided, and both were looked at during this inspection. 19 people were accommodated at the service at the time of inspection.

At our last comprehensive inspection in July 2016 we rated the service 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. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

At this inspection we found the service remained good.

People said they felt safe and they could speak to staff as they were approachable. People and staff told us they thought there were enough staff on duty to provide safe care to people. Improvements were required to hygiene in some areas of the home. We have made a recommendation to review ancillary staffing levels and staff deployment.

Staff knew about safeguarding procedures. Staff were subject to robust recruitment checks. Arrangements for managing people's medicines were safe.

Parts of the building were showing signs of wear and tear. We received an action plan straight after the inspection with timescales to show how this would be addressed.

People's privacy and dignity were not always respected with the use of shared bedrooms. We have made a recommendation to review the use of shared rooms in order to promote people's rights to privacy and dignity.

Risk assessments were in place and they accurately identified current risks to the person as well as ways for staff to minimise or appropriately manage those risks. Staff knew the needs of the people they supported to provide individual care and records reflected the care provided.

People were involved in decisions about their care. 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.

Detailed records reflected the care provided by staff. Care was provided with kindness and patience. Communication was effective to ensure people, staff and relatives were kept up-to-date about any changes in people's care and support needs and the running of the service.

People had access to health care professionals to make sure they received appropriate care and treatment. Staff followed advice given by professionals to make sure people received the care they needed. People received a varied and balanced diet to meet their nutritional needs. There were some opportunities for people to follow their interests and hobbies.

Staff were well-supported due to regular supervision, annual appraisals and an induction programme, which developed their understanding of people and their routines.

People had the opportunity to give their views about the service. There was consultation with staff and people and their views were used to improve the service. People said they knew how to complain. The provider undertook a range of audits to check on the quality of care provided.

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

Castlegate House Residential 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 10 January 2019 and was unannounced.

The inspection team consisted of one adult social care inspector.

Before the inspection, we had received a completed Provider Information Return (PIR). The PIR asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We contacted commissioners from the local authorities who contracted people's care and other professionals who could comment about people's care.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us.

We undertook general observations in communal areas and during mealtimes.

During the inspection we spoke with eight people who lived at Castlegate House, three relatives, the registered manager, a visiting registered manager, the deputy manager, two support workers, including one

senior support worker, one domestic, the activities co-ordinator and two visiting professionals. We reviewed a range of records about people's care and how the home was managed. We looked at care records for three people, recruitment, training and induction records for three staff, three people's medicines records, staffing rosters, staff meeting minutes, meeting minutes for people who used the service, the maintenance book, maintenance contracts and quality assurance audits the registered manager had completed.

Good

Is the service safe?

Our findings

People were positive about the care they received and told us they were safe with staff support. Peoples' comments included, "Staff are around if you need them" and "I do feel safe here

Staffing levels were determined by the number of people using the service and their needs. There were five staff on duty including management during the day. We identified that as ancillary staff such as catering, domestic and laundry were not on duty from 3pm and the work was then carried out by support workers this reduced the amount of direct care time with people. We also noted that activities provision was only for 15 hours of the week and observed in the afternoon people were not engaged or supported as staff did not have time to spend with people. We discussed this with the registered manager who told us it had been identified and was being addressed.

We recommend that ancillary staffing hours and staff deployment are reviewed to ensure support staff are available to provide direct care to people in the afternoon.

Improvements were required to hygiene in some areas of the home. There was a mal-odour in a communal area on the ground floor and some bedrooms. Some hallway, staircase and bedroom carpets were stained and showing signs of wear and tear. The seal surrounding some pedestal washbasins, bath panels and hand wash basins was lifting and was an infection control issue. After the inspection the provider told us this was being addressed. Staff received training in infection control and personal protective equipment was available for use as required.

Staff had receiving training about safeguarding and understood how to report any concerns. The safeguarding records showed any concerns had been logged appropriately. They had been investigated where required and the necessary action had been taken by the registered manager to address the concerns.

Medicines were managed safely. This included safe storage of medicines and appropriate arrangements for controlled drugs which are liable to misuse.

People's individual risk assessments were in place and they were reviewed to ensure they remained relevant and reduced risk to keep people safe. Regular analysis of incidents and accidents took place. Accidents and incidents were monitored and a monthly analysis was carried out to look for any trends. Learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of them recurring.

Arrangements were in place for the on-going maintenance of the buildings. Routine safety checks and repairs were carried out. External contractors carried out inspections and servicing of fire safety equipment, electrical installations and gas appliances.

Recruitment of staff was thorough. Appropriate checks had been undertaken before staff began working for the service.

Good

Is the service effective?

Our findings

Staff received training to meet people's care and treatment needs and they kept up-to-date with safe working practices. Their comments included, "There are opportunities for training", "We do face-to-face and computer training", "We have regular supervision" and "There are chances to progress in the job." There was an on-going training programme in place to make sure all staff had the skills and knowledge to support people. Some staff had also achieved or were studying for a diploma in health and social care at level three and level five in management.

Staff completed an induction programme and had an opportunity to shadow a more experienced member of staff when they started to work at the service. This ensured they had the basic knowledge needed to begin work.

There was appropriate signage around the building to help maintain people's orientation. Some parts of the building were showing signs of wear and tear. There were areas where paintwork was damaged and flooring was worn. The registered manager sent us an action plan straight after the inspection to show how this would be addressed. We discussed the five double bedrooms that were in use that did not provide the necessary furniture and space for people that used the rooms. After the inspection we were informed this was to be reviewed by the provider.

People's needs were assessed before they started to use the service. This ensured that staff could meet their needs and the service had the necessary equipment for their safety and comfort. Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives.

People were supported, where required, to access community health services to have their healthcare needs met. Their care records showed they had input from different health professionals. Visiting professionals told us staff made timely referrals for advice and followed their instructions to ensure people's health needs were met. The home had been part of a care homes project to help prevent pressure area care and were commended by the district nursing team for their good practice.

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). We saw that DoLS applications were clearly documented and where people were being restricted this was done in their best interests and the least restrictive option was always considered.

People enjoyed a varied diet and a positive dining experience. Their comments included, "We get plenty to eat", "I've put on weight, so I am careful about what I eat" and "I eat very well." Where anyone was at risk of weight loss their weight was monitored more frequently as well as their food and fluid intake. People were

offered a choice of meal and drinks. Pictorial menus were displayed to help people make a choice if they no longer understood the written word. People sat at well-set tables and staff were supportive to people and offered full assistance as required.

Good

Is the service caring?

Our findings

All people, relatives and visitors were complimentary about staff. They were very positive about staff support and people told us they felt valued by staff. Their comments included, "Staff are very kind", "Staff are brilliant" and "Staff have helped me." A relative told us, "It is like a family." A professional told us, "You will only hear positive things about Castlegate House, it has a good reputation."

Positive, caring relationships had been developed with people. Staff interacted with people in a kind, pleasant and friendly manner. There was a stable staff team with some staff having worked at the service for several years. Staff were given training in equality and diversity and person-centred approaches to help them recognise the importance of treating people as unique individuals with different and diverse needs.

Staff were knowledgeable about the people they supported. They were aware of their preferences and interests, as well as their health and support needs, which enabled them to provide a more personalised service. People's care records were up-to-date and personal to the individual. They contained information about people's likes, dislikes and preferred routines.

All of the people we spoke with confirmed they were involved in in making decisions about their care and support. They told us they were able to decide for example when to get up and go to bed, what to eat and what they might like to do. One person said, "It's my choice, I like to get up early." People's care records also stated how they could be involved in making choices.

People's privacy and dignity were mostly respected. However, ten people did not have their own bedroom as they shared a bedroom. This meant they did not have their privacy or a place where they could spend time on their own if they wanted their own space. We observed a privacy curtain was available in these bedrooms if people needed to use a commode however it was not private and soundproofed to respect people's dignity.

We recommend the provider reconsiders the provision and use of shared bedrooms for people who are not in a relationship.

People were supported to maintain their independence whenever possible and personal preferences were respected. Staff understood the importance of people maintaining their independence and the benefits it had for their well-being. We observed people were supported by staff to use a walking frame or 'zimmer frame' to help them walk, where possible, rather than a wheelchair. One person, who was staying for respite was being rehabilitated and supported by staff to become more physically independent so they could return home.

The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand

information they are given. Information was accessible and was made available in a way to promote the involvement of the person. For example, by use of pictures or symbols for people who did not read or use verbal communication.

Advocates were used as needed to represent the views of people who were not able to express their wishes, or had no family involvement.

Good

Is the service responsive?

Our findings

People and relatives confirmed they had a choice about getting involved in activities. Their comments included, "We go to the park", "We have picnics in the summer", "We play bingo", "I get my newspaper delivered" ,"We do word searches and I had a game of dominoes today" and "Entertainers come in."

An activities programme was advertised along with available and forthcoming entertainment. An enthusiastic activities co-ordinator was available in the morning to engage with people and we observed they carried out group and individual activities with people. However, we observed people were not engaged and stimulated in the afternoon as staff were busy and an activities person was not available. We discussed this with the registered manager who told us it would be addressed.

The registered manager told us there were good links with the local community. Local schools, including nursery schools visited. Relatives and people also stated the service was part of the local community. The hairdresser visited weekly and local members of the clergy visited monthly. People had some opportunities to go out on trips when the weather was good. People were encouraged and supported to maintain and build relationships with their friends and family.

Care plans were developed from assessments that outlined how people's needs were to be met. For example, with regard to nutrition, personal care, communication and moving and assisting needs. Care plans provided some detail of what the person could do to be involved and to maintain some independence. Records showed that monthly assessments of peoples' needs took place with evidence of evaluation that reflected any changes that had taken place. Evaluations included information about people's progress and well-being. Records accurately reflected people's care and support requirements.

Records showed relevant people were involved in decisions about a person's end-of-life care choices when they could no longer make the decision for themselves. People's care plans detailed the 'do not attempt cardio pulmonary resuscitation' (DNACPR) directive that was in place for some people with regard to their health care needs. However, information was not available about the end-of-life wishes of people, as they approached death. This included people's spiritual requirements and funeral arrangements and who they wanted to be involved in their care at this time. We discussed this with the registered manager who told us it would be addressed.

Staff completed a daily accountability record for each person and recorded their daily routine and progress in order to monitor their health and well-being. This information was then transferred to people's support plans.

People and relatives were engaged in the day-to-day operation of the service. There were meetings and surveys to gain people's opinions about care. A record of complaints was maintained. People told us they could talk to staff if they were worried and raise any concerns. The compliments log showed there were

several compliments received about the care provided by staff.

Good

Is the service well-led?

Our findings

A registered manager was in place who had registered with the Care Quality Commission in June 2015.

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 understood their role and responsibilities with regard to safeguarding and notifying the Care Quality Commission (CQC) of notifiable incidents. They had ensured that notifiable incidents were reported to the appropriate authorities and independent investigations were carried out if necessary.

The registered manager assisted us with the inspection. Records we requested were produced promptly and we were able to access the care records we required. The staff team were open to working with us in a cooperative and transparent way.

Staff and people we spoke with were all very positive about the management and had respect for them. Comments included "The manager is very, very approachable", "The manager is lovely" and "The manager and staff are very helpful."

The atmosphere in the service was welcoming and friendly. A variety of information with regard to the running of the service was displayed to keep people informed and aware and this included the complaints procedure, activities, safeguarding, advocacy and forthcoming events.

Staff members were champions and had lead responsibility for an area of interest for which they promoted best practice within the home. For example, infection control and pressure area care. The registered manager told us of their plans to extend these areas to include dementia awareness.

Staff told us and meeting minutes showed regular meetings took place to keep staff updated with any changes in the service and to allow them to discuss any issues. One staff member commented, "We have staff meetings regularly and I do feel listened to." Staff said communication was effective. A handover session took place, between staff, to discuss people's needs when staff changed duty, at the beginning and end of each shift.

Regular audits were completed internally to monitor service provision and to ensure the safety of people who used the service. The audits consisted of a wide range of daily, weekly, monthly, quarterly and annual checks. They included the environment, health and safety, medicines, infection control, finances, safeguarding, complaints, personnel documentation and care documentation.

People and their relatives were kept involved and consulted about the running of the service. The registered provider monitored the quality of service provision through information collected from comments, compliments, complaints and survey questionnaires that were sent out to people who used the service, staff and relatives.