Peter Michael Mayhew

Smyth House

Inspection report

106 High Street
Leiston
Suffolk
IP16 4BZ

Tel: 01728831373

Date of inspection visit:
02 March 2016
03 March 2016

Date of publication:
25 May 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Smyth House Care Home provides accommodation and personal care for 18 older people, some living with dementia.

There were 14 people living in the service when this inspection took place on 2 and 3 March 2016. This was an unannounced inspection.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People living in the service told us they felt safe and well cared for by the staff. People told us and we observed positive and trusting relationships between staff and people living in the service.

Staff had received training on how to recognise different types of abuse and were confident that if they raised any concerns, appropriate action would be taken.

Individual care records were in the process of being updated to reflect people's individual needs and preferences. Risk assessments were in place to guide staff on how to minimise risks to people, but some records did not contain paper versions of the risk assessments which could be necessary to prevent delay in the event of an emergency.

There were appropriate arrangements in place to ensure people's medicines were stored and administered safely.

Safe recruitment procedures and checks were followed to ensure people working in the service were of good character and suitable for the role.

Staff felt well trained to do their job, but had not updated their skills and knowledge in Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training. Staff obtained consent from people before they provided their care, but had a mixed understanding of how capacity was assessed and the consideration of DoLS when a person was receiving medicines covertly.

People were supported to have a varied and balanced diet. Staff knew people's preferences and were aware of any additional dietary needs.

People were referred promptly to other health professionals when needed, and were often pre-emptive in their approach.

Staff had a caring and compassionate approach to people living in the service and knew them well. We observed positive and respectful interactions between staff and people. People's privacy and dignity was respected.

People were provided with group activities such as bingo, skittles and entertainers who came into the home. However, further opportunities for additional activities could be developed in future improvement plans following feedback received from people living in the service. We have made a recommendation about meaningful activity for older people.

People living at the home, their relatives and staff alike all thought the home was well led and spoke positively about the manager and staff group. Visitors to the home felt welcomed and always listened to.

Because staff and management knew the people living in the service well, formal resident meetings were not held to encourage people to express their views, however, staff asked for people's views on an individual basis and people we spoke with felt satisfied with this arrangement.

Relatives told us that they found the registered manager to be approachable and supportive. They set a homely and relaxed culture within the service, however, more robust monitoring and oversight is needed from the management team to ensure the service strived for continual improvement in what it provided to people living in the service.

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.

People told us they felt safe and well cared for by staff who knew them well.

Medicines were provided to people when they needed them and in a safe manner.

Risk to people was reviewed, and care records were in the process of being updated.

Safe recruitment procedures were in place to ensure that staff were suitable for their role.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were supported by staff who felt well trained to do their job.

Staff knowledge regarding depriving people of their liberty was inconsistent.
Staff had not received training updates in this area.

People were supported to maintain good health and had access to appropriate services which ensured they received ongoing healthcare support.

People were supported to have enough food and drink, and staff understood people's nutritional needs.

Is the service caring?

Good

The service was caring.

People were cared for with kindness and respect by staff who knew them well.

People felt listened to. Staff spoke to people on an individual

basis when asking for their views and decisions about their care.

People's privacy and dignity was respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People received personalised care which was responsive to their needs; however, information held on care records was inconsistent.

People were supported to take part in social activities, but feedback from people living in the service identified the need for more opportunities.

People were asked for their views and felt confident to speak up.

People and relatives knew how to complain and felt confident to do so.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The service had an open and inclusive culture.

Management and provider oversight of the service required improvement to ensure that governance systems and processes were monitored effectively, and used to drive continual improvement.

Smyth House

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 2 and 3 March 2016, was unannounced and undertaken by one inspector.

Prior to our inspection we looked at information we held about the service which included notifications. Notifications are information the registered provider is required to send to us to inform us of significant events.

To help us assess how people's care needs were being met we looked at five people's care records, four staff recruitment files, maintenance files and a selection of records which monitored the safety and quality of the service.

We spoke with seven people who used the service, five people's relatives and one visiting health professional. We also spoke with the registered manager, the deputy manager and five members of staff including care and catering staff.

Good

Is the service safe?

Our findings

People in the service told us they felt safe. One person said, "I never wait long if I ring my buzzer, staff are always around". Another said "I feel very safe here, if I fall someone always comes quickly". The service liaised with health professionals regarding people who were at risk of falls.

Staff had received training in how to safeguard people from harm and how to recognise signs of abuse. They were able to describe different types of abuse and who they would contact if they were concerned that a person was being abused. A member of staff told us, "I would report any concerns to the manager immediately". The service also promoted this message to visitors by displaying details of who to contact in the event that a person was being abused.

Individual risk assessments were in place which identified risks that could affect people such as, falls, skin integrity, nutrition, and health conditions. These risk assessments provided staff with guidance on how the risks in people's daily lives were minimised. The service used an electronic system to record care plans, risk assessments and daily notes. There were also paper records in place for staff to refer to. However this led to some inconsistencies in what was included in each person's care record; for example, one person's paper care record did not have the risk assessments because they were held on the electronic system. Another person's care plan was not in the paper record but held electronically. Our observations were that staff knew people well and individual needs were being met. The registered manager told us they would ensure that improvement was made to people's care records which would contain consistent, accurate and up to date information relating to their individual care needs and risks. This was in the process of being completed on the day we inspected.

There was a record of accidents and incidents which occurred. The registered manager told us that when people had fallen they sent the information to the local surgery so the GP's could review and monitor these. We spoke to a GP at the surgery who confirmed that these were discussed within monthly multi-disciplinary meetings to identify patterns and visit the person if the cause was health related and intervened to reduce the risk of further falls. This demonstrated that the service maintained effective links with health professionals to reduce risks to people.

People told us they felt there were enough staff to meet their needs and had no concerns about the staffing levels. One person said, "I prefer my own company, but the staff always come in and see me regularly, which is good". A staff member said, "Yes staffing is good, I can always find someone else to help if I need it". The registered manager assessed staffing based on people's dependency levels which at present were not considered to be high. The registered manager said that if people's needs increased then they would adjust staffing levels according to need. Staff told us that the registered manager stepped in if needed, for example, in the event of staff sickness. They told us that they were able to use existing staff to cover other shortfalls which ensured that people were cared for by staff who knew them well.

People lived in a safe environment. Maintenance records were checked and regular servicing of equipment had been carried out on items such as lifts, hoists, stair lifts, and electrical equipment.

The service had recently acquired a 'Grab Bag'. Their purpose being to save time in the case of emergencies, and contained basic items for first aid.

There were Personal Emergency Evacuation Plans (PEEP) for people living in the service. These plans outlined the support people required to evacuate the building in an emergency situation. On checking these records we found that some plans had not been updated to reflect changing needs which may mean people would be put at risk in the event of an emergency. We brought this to the registered manager's attention, and on the second day of our inspection we saw that these had all been updated. This demonstrated that the service took prompt action to rectify this and minimise these risks.

Records confirmed that appropriate checks had been made to ensure staff were of good character before they were allowed to work in the service. Staff confirmed that reference checks and Disclosure and Barring Service (DBS) checks (which provides information about people's criminal records) had been undertaken before they started work. One relative told us, "The staff are all lovely here, really caring and a very friendly team".

We looked at the systems in place for managing medicines and found there were appropriate arrangements for their safe handling. All staff who administered medicines were trained to do so. People were happy with how staff supported them to manage their medicines. One person said, "I have tablets three times a day, and they are always on time, and if I need to have painkillers they bring them". Another told us, "I get regular medication every day, I have no complaints". We saw that where people required medicines at a specific time of day, or an hour before eating, staff were fully aware and medicines were provided in a timely manner. We checked the storage of controlled drugs and found that these were kept securely, and stock checks were correct.

For some people medicines were prescribed PRN [as or when required]. PRN protocols were in place to guide staff on when this should be offered, for example, what symptoms a person may display if they were in pain.

Medicines were sometimes given within a communal area, but staff were observed to be discreet when speaking with people and when assisting people to take their medicines.

The service undertook monthly audits for medicines, and actions were logged if issues were identified, for example staff reading policies or additional staff training.

Requires Improvement

Is the service effective?

Our findings

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 decision made on their behalf must be in their best interests and as least restrictive as possible.

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). The MCA DoLS requires providers to submit applications to a 'Supervisory Body' for authority to restrict people's liberty.

Staff had a mixed understanding of the principles of MCA and DoLS. They understood why they needed to gain consent from people to provide care, but were not knowledgeable about what DoLS meant in practice. This knowledge would enable staff to recognise when to take action, for example if a person's needs changed, or if a person moved into the service who needed support in this area. It would also safeguard against a person being unlawfully deprived of their liberty. One staff member said they had never received DoLS training, another told us they had not had an update for over three years, and another could not remember when they last had this training. The registered manager confirmed that all staff working within the service required an update in their MCA/DoLS training, and took immediate action to rectify this by contacting the services' training provider to arrange updates for all staff.

We saw that a Best Interests decision was in place for one person, detailing what alternatives had been considered to ensure the least restrictive options. The records showed the service had consulted with the GP, nurse practitioner, family and staff about administering medications covertly [without their knowledge] however, this had not been reviewed for eight months, and the document stated it should be reviewed on a monthly basis. In addition the effect of the medication prescribed had not been considered as a potential DoLS referral. The registered manager said they would discuss this again with the professionals involved to ensure the person's rights were being protected, and subsequently made a DoLS application to the Local Authority.

People were asked for their consent before staff supported them with their care needs, for example to mobilise or assisting them with their meal. However, during the lunchtime period a staff member placed a clothes protector over a person's head from behind without first asking if they wanted this put on. The registered manager told us that they were confident that staff were performing their duties in line with the principles of MCA and DoLS and this was not usual practice. People told us that their needs were met by staff who worked in the service. One person said, "The girls [staff] know me well, they know what I need and do a good job".

Staff received training which reflected the needs of those they cared for. Staff told us they felt well trained to

do their job. They received training in safeguarding, moving and handling, infection control and medicines. Some had additional training in areas such as diabetes and dementia, and we saw that further dates for training in diabetes care had been secured. Staff working in the home had recognised national qualifications in care. The service's training provider confirmed that they were currently involved with training staff in moving and handling of people, and they are assessing three staff members who had enrolled on their level 2 Diploma in health and social care. Training and development of staff was considered an important part of staff roles. Staff and management told us this helped them to provide safe and effective care for people.

There was a staff induction pack for new staff members which included 'care certificate' training information and a booklet for staff to complete so the registered manager could assess their current level of knowledge. A newer member of staff told us they were being inducted into their role by experienced team members, had booked onto mandatory training, and were being supervised by a member of staff until they gain confidence in the role. This meant the service was ensuring new staff members were supported and assessed during their probation period to ensure their suitability for the role.

Supervisions and appraisals provide staff with the opportunity to discuss how they are working, receive feedback on their practice and identify any training needs. The registered manager told us that they tried to ensure staff were offered formal supervision six times a year, and had started to arrange staff annual appraisals. The registered manager ensured good communication on an informal basis so staff felt involved and valued. One staff member said, "I feel involved in the service and in the running of it". The registered manager told us that the staff team did not have regular team meetings as they keep staff updated informally. We asked staff how they felt about this and staff agreed that they knew what was happening in the service despite not having formal meetings.

People were supported to have sufficient to eat and drink and to maintain a balanced diet. One person told us, "Plenty of good food, they get me anything I need food wise". Another said, "Lovely meals here". We saw that menus were displayed on the wall in the dining area on a four weekly basis.

During lunch we saw that all people were served the same portion size and we asked why people were not offered different amounts to acknowledge individual preferences. The registered manager told us that they knew people well and what their preferred portion size was, but people could have more if they chose to. One person's relative told us "[Name of person] has a healthy and balanced diet which has helped them to lose weight and improved their health". The service took account of people's dietary needs, for example, diabetic diets, and made reference within people's care records as to foods they should avoid and the effect that unhealthy foods would have on their health. By doing this the service had assessed potential risks to people's health by monitoring their dietary requirements.

Staff asked people if they needed help to cut up their food before doing so, and were offered drinks throughout the meal. There was a relaxed atmosphere during lunch, and staff were available at all times. We observed throughout the day that people were offered drinks on a regular basis, and that there were also drinks available for people to help themselves.

We spoke to the chef who told us that they catered for people who required a diabetic diet or who needed a softer diet, and that they knew people's needs well and how much people liked to eat.

People were supported to maintain good health. The service routinely referred people to health professionals as needed, this included during the inspection, where people were being seen by the community nurses, and people being referred to the GP. A health professional told us, "The home are very

good at referring people quickly when they need it, they ask for advice which can result in a visit to the person or advice via a phone call, but they always follow the advice".

Good

Is the service caring?

Our findings

People were very positive in their account of the care they received. One person told us, "The staff are all very kind, we have a laugh and a joke". Another said, "No faults with anyone, the girls [staff] are all lovely".

Our observations confirmed that staff knew people living in the service well. Staff interacted positively with people and showed kindness and respect when speaking with them and listened to what people were saying. A relative told us, "People get good care here, we can always speak with staff if we have any questions about [person's] care".

Staff knew people's preferences and routines well, such as what time they liked to get up, how they liked to spend their day, where they liked to sit, and what interests they had. A staff member told us, "The people who live here become your family, we know them all so well". We saw that staff had developed trusting relationships with people and that people appeared relaxed with staff. The activities co-ordinator had started to complete life story books with people, and staff were seen to take an active interest in the lives people had led before moving into the service.

People told us they felt listened to. The registered manager told us that because the service was small and because they and the staff knew people well, they did not hold formal 'resident' or 'relative' meetings. Instead they spoke with people individually and asked them if they were happy with their care and made changes if needed. There was therefore no way to review the effectiveness of this approach in ensuring and demonstrating people were actively involved in their care. The services' training provider told us, "I have regularly witnessed staff offering residents choice and opportunities whether in activities or food and drink options. Staff try to find time to sit with residents too, engaging in conversation and demonstrating value".

The registered manager told us that there was a 'rounds' book in place where staff were documenting feedback from people, so any requests could be monitored and changes made accordingly. There were no formal meetings for people to feedback their views, however people told us they were happy with the arrangements in place. One person told us, "I don't need a meeting, I get what I need". Another said, "Not really I'm happy with everything". A relative told us, "We don't need meetings, we just speak to staff".

The registered manager told us how they encouraged advocacy within the service, and showed us the contact details for local advocacy services if needed.

People told us they were treated with dignity and respect and we observed this. For example, we saw that staff knocked on people's bedroom doors before entering, even if the door was already open. We also saw that people who preferred their own company were enabled to sit in a particular area away from others. One person told us that due to a health condition, they needed their room cleaned more often and this was important to them. They told us the registered manager always ensured the carpet was regularly cleaned to avoid any odours developing in their bedroom. This demonstrates that the service listened to people and tried to ensure that their privacy, dignity and issues that mattered to them were respected.

Relatives were permitted to visit at any time, and spoke positively of the service. One relative told us, "I have no concerns whatsoever; if I do I speak up, but haven't needed to". We observed that relationships had also been built up between staff and relatives, and they were greeted warmly on arrival and when leaving.

Requires Improvement

Is the service responsive?

Our findings

People told us they received care that was responsive to their needs. One person said, "They [staff] know me well, they know what I like". A relative said, "Any changes I've asked for in [person's] care they [staff] have done, nothing but praise".

Staff demonstrated knowledge of people that enabled them to support them the way they preferred. Staff knew people's individual likes and dislikes. Care records were person-centred, identifying important individual preferences, such as what time people liked to get up, their food preferences, favourite films and their preferred routines for the day.

Staff were in the process of updating people's care records when we inspected. There was a member of staff allocated who was responsible for reviewing care records on a monthly basis. When reviewing the records, it was not immediately clear what the person's current needs were, but this was due to the format of the template the service was using, and also the electronic system was not functioning fully on the day we inspected. As soon as we brought this to the registered manager's attention, they and a member of staff began to update both the paper and electronic records to ensure accuracy in the information held. Staff told us that they always involved people in their care planning, but people had not signed to demonstrate their involvement.

The service had effective communication systems in place to ensure information was passed between shifts in a timely manner. This included updates on people's health and when referrals needed to be made to other professionals. Staff attended a handover meeting before starting their shift so important information could be shared, such as if a person had become unwell, and the general well-being of people. This ensured that people were provided with care from staff who were up to date with their current needs.

There was an activity co-ordinator in the service who worked 12 hours per week over four sessions. Group activities were provided, such as skittles and bingo. People were also encouraged to follow their own interests and hobbies, for example, with knitting, adult colouring books, reading and TV. One person told us, "I like knitting and there's nothing else to do at the moment". One person had a set routine of different tasks they carried out in the morning and afternoon, and staff supported them to do so. One person said, "I like to stay on my own in my room, but as you can see I have everything I need to keep me busy". Another said, "The manager comes in every day and asks if I need anything".

Whilst people were positive about the activities provided some people needed support to do more. One person told us, "Sometimes singers come in and we sing along, its lovely, would like more of that". Another said, "I feel frantic to get out sometimes but they [staff] can't always spare the time". The activities co-ordinator told us they did take people into town, but as they were only available four sessions per week this could be difficult. We discussed this feedback with the registered manager during the inspection.
People were supported to maintain contact with family and friends. Relatives were very complimentary about the staff and management. One relative said, "I'm very happy with the systems here, we just speak to staff as we need to, and we come and go as we please".

The registered manager told us that they had not received any complaints or concerns for a long period of time, but if they did they would respond promptly. We saw a log of complaints which were reported in the past, and action had been taken to address concerns raised. We observed that relatives knew the staff team well, and any complaints could be raised directly with staff or management. People told us they knew how to complain, and who they would speak to. One person said, "I would tell the manager, no problem there". Another said, "I can talk with [name of manager] they would listen to me".

We recommend that the service explores current guidance from a reputable source about how to support people in meeting their individual needs in relation to spending time in meaningful and fulfilled ways (for example NICE guidelines for mental wellbeing in over 65s: occupational therapy and physical activity interventions).

Requires Improvement

Is the service well-led?

Our findings

The registered manager told us that they had not been present in the service for a short period of time which had resulted in them losing some oversight of the service in terms of monitoring systems and processes. For example, they had lost oversight of ensuring staff were trained in important areas such as MCA and DoLS. Planning is required for periods when the registered manager is not present in the service to ensure consistency when they are not available.

People told us they felt listened to and would speak to staff on an informal basis with any issues or concerns they had. However, the service could not demonstrate the action they took in these circumstances and how they ensured lessons were shared, learned from and used to improve the overall service. The provider's Statement of Purpose did not reflect some of the practices at the service accurately, noting that, "Minutes of the resident meetings must be kept on file". As there were no meetings held we were unable to review this information. It also said, "Activities must be devised via consultation with service users and amended as needed to changing views", however, the service could not demonstrate this was the case, and people commented to us they wanted more activities available and opportunity to go out. Whilst the registered manager took prompt action to address these issues they and the provider had not independently identified that improvements were needed.

People knew who the registered manager and provider were as they were both a regular presence in the service. One person said, "The manager is lovely she comes and sees us regularly". One staff member told us, "If I had any concerns I'd go straight to [name of manager]. I feel valued and listened to". A relative said, "Absolutely great, I have known the manager for years, and I have no concerns".

The registered manager demonstrated a compassionate and caring approach to their role. It was clear during our observations that they had a warm, friendly relationship with people and that there was a positive and open culture in the service. Staff told us that they were clear about their roles and responsibilities, were positive about the registered manager, and said they felt involved in the service and valued. People, relatives, and staff commented about the 'family' orientated ethos the service had. The service was relatively small and therefore staff knew people and relatives well. Some of the staff had worked in the service for a significant number of years, which meant they had developed strong relationships with those they cared for.

Providers are required to send the CQC statutory notifications to inform of certain incidents, events and changes that happen. Whilst the registered manager had sent in statutory notifications to the CQC, they had not always sent in all notifications when they were required, for example, an injury which had occurred. We advised the registered manager to familiarise themselves with the range of incidents that require a notification to be sent to the CQC.

Quality assurance checks such as audits had been carried out in some areas, such as monthly medicine audits, and care records were being produced in a new format to improve the quality of information held, however, more robust monitoring and oversight was needed to ensure the service strived for continual

improvement in what it provided to people living in the service.

The registered manager kept their knowledge up to date by referring to Care Quality Commission guidance, professional journals, and was a member of the Suffolk Association of Independent Care Providers and attended regular meetings. They told us that this ensured that they could keep up to date with information such as training, medical device alerts, sharing knowledge and best practice, and an opportunity to discuss concerns with other small care providers.