Avery Homes SH Limited

# Spencer House Care Home

## Inspection report

Cliftonville Road
Northampton
NN1 5BU

Date of inspection visit:
06 November 2017

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01 January 2018

## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| 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

Spencer House Care Home provides accommodation to provide nursing and personal care for up to 64 people. The home provides a permanent home for up to 40 people; areas of the home are divided between residential care on Althorpe and dementia care on Churchill.

The home also works in partnership with the local NHS hospital (Northampton General Hospital) to provide care for up to 24 people on Blenheim Ward; where people are still under the medical care of the hospital and are being assessed for discharge from hospital. Medical and therapy staff from the hospital work in the home alongside nursing and care staff from Spencer House Care Home to provide all care.

The home consists of three floors, communal areas and gardens in the town of Northampton, Northamptonshire.

At the last Care Quality Commission (CQC) inspection on 17 May 2016, the service was rated as Good. Before this inspection we received information of concern regarding staffing levels on Blenheim Ward which had an impact on the quality of people's care. We planned to inspect again in summer 2018, but brought forward the inspection due to these concerns. At this inspection we found that the provider had identified the staffing issues and responded appropriately to ensure people received their planned care.

People continued to feel safe. Staff understood their roles and responsibilities to safeguard people from the risk of harm. Risk assessments were in place and were reviewed regularly.

Staffing levels ensured that people's care and support needs were safely met. Safe recruitment processes were in place.

People received care from staff that had received training and support to carry out their roles. People were supported to have enough to eat and drink to maintain their health and well-being.
People were supported to access relevant health and social care professionals. There were systems in place to manage medicines in a safe way.

Staff demonstrated their understanding of the Mental Capacity Act, 2005 (MCA). Staff gained people's consent before providing personal care. People were involved in the planning of their care which was person centred and updated regularly.

People were encouraged to make decisions about how their care was provided and their privacy and dignity were protected and promoted. People had developed positive relationships with staff. Staff had a good understanding of people's needs and preferences.

People were listened to, their views were acknowledged and acted upon and care and support was delivered in the way that people chose and preferred.

People using the service and their relatives knew how to raise a concern or make a complaint. There was a complaints system in place and people were confident that any complaints would be responded to appropriately.

The service had an open culture which encouraged communication and learning. People, relatives and staff were encouraged to provide feedback about the service and it was used to drive continuous improvement.

The provider had quality assurance systems to review the quality of the service to help drive improvement.

## 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 received care from staff that knew how to safeguard people from abuse.

People's risks were assessed and reviewed regularly or as their needs changed.

There were sufficient qualified staff to support people to stay safe. People were protected from the risk of unsuitable staff as the provider followed safe recruitment procedures.

People received their prescribed medicines as planned as staff followed safe medicines management procedures.

People were protected by staff who followed procedures to help prevent and control infections.

People could be assured that staff continually learnt from incidents and improvements were made when things go wrong.

### Is the service effective?

Good

The service was effective.

People received care that was delivered in line with current legislation, standards and evidence based guidance.

People were cared for by staff that received the training and support they required to carry out their roles.

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

People were supported by staff that worked well across organisations to ensure safe admission, discharge and transfer of care.

People's needs were met by the adaptation design and decoration of the premises.

People's consent was sought before staff provided care. Staff understood their responsibilities in relation to the Mental Capacity Act 2005 and DoLS.

## Is the service caring?

Good

The service was caring.

People were treated with kindness and respect by staff.

People were supported to be involved in planning their care.

People's privacy and dignity were maintained and respected.

## Is the service responsive?

Good

The service was responsive.

People received care that met their needs and had plans of care that were updated as their needs changed.

People had information on how to make complaints and the provider had procedures they followed to manage and learn from complaints.

People were supported to plan and make choices about their care at their end of life.

## Is the service well-led?

Good

The service was well led.

There was a registered manager who understood their roles and responsibilities.

The provider had a clear strategy and vision to deliver high-quality care.

The provider had procedures in place to monitor the compliance and quality of the service and had systems in place to take action to improve where necessary.

People and their representatives were involved in developing the service.

# Spencer House 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 checked 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 unannounced comprehensive inspection took place in response to concerns about staffing levels impacting on the quality of people's care. The inspection was carried out on 6 November 2017 by three inspectors and two experts 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.

Before our inspection, we checked the information we held about the service including statutory notifications. A notification is information about important events which the provider is required to send us by law. We contacted the health and social care commissioners who monitor the care and support of people living at Spencer House Care Home.

We observed care and support being provided in the communal areas of the service. We used a Short Observational Framework for Inspection (SOFI 2).This was so that we could understand people's experiences. By observing the care received, we could determine whether or not they were comfortable with the support they were provided with.

During this inspection we spoke with 30 people using the service and three of their relatives. We spoke with 13 members of staff including the representative of the provider, the registered manager, the deputy manager, two nurses, two senior staff, three care staff, the cook, laundry staff and a member of staff responsible for 'guest relations'.

We observed the interactions between people who used the service and staff. We reviewed the care records of eight people that used the service and the recruitment records for five members of staff. We also reviewed records relating to the management and quality assurance of the service.

Good

# Is the service safe?

## Our findings

We received information of concern regarding the levels of nursing staff on Blenheim Ward which had impacted on the care that people received. We received information from staff and other organisations. We reported these to the local authority safeguarding team who visited the home and found no concerns.

There were sufficient skilled staff to provide safe care for people admitted to Blenheim Ward for short term nursing care and assessment. In August and September 2017 the provider had identified inconsistencies in staffing and had taken action to rectify these. The registered manager continually monitored the staffing levels to ensure they could meet people's care needs. People told us they felt there were enough staff to meet their needs; one person told us "I feel safe here there's plenty of good staff around." The provider ensured that in addition to the care staff there were two nursing staff during the day, however nurses worked extra shifts and bank staff were booked to cover any remaining shifts. At times there was one nurse in the evenings; staff told us that this relied on nursing staff feeling confident, one nurse told us "I always ask the manager to book a bank nurse to work with me if I am rostered [as the only nurse] as it is very busy in the evenings." Staff had access to clinical support from experienced nursing staff at the neighbouring home situated on the same site or the area manager.

The registered manager had recognised the need for a clinical lead and was developing the roles of key staff and had recruited two more nurses for Blenheim Ward.

We recommend that the role of clinical lead is developed as a matter of priority to allow for nurses clinical support and development.

There were enough experienced staff to safely meet the needs of people who lived permanently in the home on Churchill and Althorpe floors. The provider had systems in place to calculate the number of staff required according to people's dependency. One person told us "I feel safe here; it's a nice atmosphere with nice staff. You cannot fault them they are wonderful." One senior care worker told us "Our staffing has been reduced recently because we have four vacant rooms (on Churchill), the staffing is manageable, and we are able to deliver the care." Another member of staff told us that in addition to the staff allocated to each floor, "At night one staff floats between Churchill and Althorpe as additional support, it works well."

The registered manager followed safe recruitment and selection processes. One member of staff told us "I had all my pre-employment checks done before I started work here, including an interview and references." Staff recruitment files contained all relevant information to demonstrate that staff had the appropriate checks in place. These included written references and a satisfactory Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

People were supported by staff that understood their responsibilities to safeguard people from the risk of harm. Staff demonstrated they knew how to raise any concerns with the right person if they suspected or witnessed ill treatment or poor practice. One member of staff told us that they looked out for people's

welfare; they said "You need to listen to people and understand their experience." One nurse told us "I would record everything and report to the manager who would raise the safeguarding alert." The registered manager had raised safeguarding alerts appropriately and had systems in place to investigate any concerns if required to do so by the local safeguarding authority. The provider had a positive culture where safeguarding was discussed at team meetings.

People's risks were assessed and reviewed regularly, for example for their risk of falls. Risk assessments reflected people's current needs and staff were provided with clear instructions in care plans to mitigate the assessed risks. For example one person was prone to falls; they had a low bed, a crash mat next to their bed at night in case they rolled out. The risk assessments and care plans were reviewed regularly or as people's needs changed.

There were fire risk assessments and fire safety procedures in place to check that all fire safety equipment was serviced and readily available. Staff had received training in fire procedures and each person had been assessed for their mobility in the event of an evacuation. Staff told us they had practiced the fire procedures. The provider carried out regular environmental checks and maintenance of equipment such as hoists, radiators and window restraints. They completed regular checks on the temperature and cleanliness of the water supplies.

The registered manager analysed information they gathered in relation to falls, accidents, complaints and safeguarding alerts to understand how these had occurred. They shared the information with senior staff at meetings where they discussed possible solutions and learning from these incidents. One member of staff told us "There is always something we are learning and improving, we have improved how we recorded the administration of medicines to help prevent medicine errors."

There were appropriate arrangements in place for the management of medicines. Staff had received training and demonstrated they were knowledgeable about how to safely administer medicines to people. One person told us "My medication is always on time and it's reviewed." Records showed that people received their medicines at the prescribed times. People could ask for pain relief; staff provided medicines as required such as Paracetamol and recorded the reasons and the effects. One person told us "I do take painkillers for my legs which the nurse gives me when I need them". Staff understood when to refer people to their GP's for medicines reviews, such as when medicines were no longer effective or people found tablets difficult to swallow.

People were protected from the risks of infection as the provider had infection control procedures that staff followed. There were procedures in place for cleaning schedules and these were monitored for effectiveness. People told us the home was clean, "I have no complaints about cleanliness" and "It's beautifully clean." Relevant staff training in infection control and food hygiene had taken place, and the service had a five star food hygiene rating from the local authority. Five is the highest rating awarded by the Food Standards Agency (FSA). This showed that the service demonstrated very good hygiene standards.

People told us that staff used gloves and aprons when providing personal care or changing bed linen. One person told us "Staff do use gloves and put them on all the time. I have had no infections since being here. I have a bed bath or shower every day." Nursing staff followed protocols to screen people for infections and recorded when people were admitted to the home with infections. The registered manager had allocated a member of staff to be the infection prevention lead who audited all infections and how they were treated; this information was used to discuss the effectiveness of infection prevention in the home with the commissioners of the service.

Good

# Is the service effective?

## Our findings

People's treatment and support were delivered in line with current standards and guidance. The provider had clinical oversight of the risk assessment tools and procedures used in all of their homes and had systems in place to monitor their effectiveness and update and adapt where necessary. Nursing staff remained up to date with current practice in pressure area care, medicines management, catheter care and infection prevention. One nurse told us "We update and help each other in our clinical practice." Risk assessments were based on national guidelines. The provider had systems in place to continually update their practice in line with evidenced-based guidelines.

People received care from staff that had the skills and knowledge to meet their needs. All new staff had an induction where they received training in core areas such as health and safety, moving and handling, dementia awareness, understanding the mental capacity act and safeguarding of vulnerable adults. New staff received close supervision and shadowed more experienced staff and were assessed for their suitability and competency during their probation. The provider had a specific training programme for senior care staff to enhance their knowledge and skills and help them to lead teams.

People were cared for by staff that received support and encouragement from the provider to enable them to carry out their roles. Nursing staff had access and support of other clinical staff from the area manager and nursing staff in the neighbouring home also run by the provider. Staff receive regular supervision. One member of staff told us "I have supervision every month; it's very helpful as I can discuss personal development or make suggestions to improve the service." Staff were encouraged to study for vocational qualifications.

People were assessed for their risks of not eating and drinking enough to help maintain their health and well-being. People received food and drink that met their individual needs. For example where people were assessed as at risk of choking their food was pureed and their drinks were thickened. Staff understood how to support people to maintain their weight by fortifying their food and drinks. People living with dementia were helped to choose what they ate by staff showing them options of ready plated food. People told us they enjoyed the food provided, one person said "The soup is particularly good and there's always enough food and never rushed."

The provider, registered manager and nursing staff worked closely with the local general hospital to ensure that communication about admissions and standards of care were managed safely. There were regular meetings where people's experiences and outcomes were discussed. People's cultural needs were accounted for in the menu and people could request additional specific foods that they particularly liked. The provider used these meetings to learn from incidents and improve the communication and standards of care. This had led to changes in the way staff access the medical staff. Hospital staff such as the physiotherapist and occupational therapist worked in the home assessing people for discharge; they told us that the communication between them and staff was good. The registered manager held regular meetings with staff to communicate changes in policies, practices and guidelines. Staff had opportunities to feedback their experiences and ideas which were used to further improve the service.

On Blenheim Ward, nursing staff monitored people's vital signs such as pulse and blood pressure regularly and sought medical attention where people's health deteriorated. On Althorpe and Churchill people were supported by staff that were vigilant to people's changes in behaviour and well-being that could indicate a change in their health. Staff followed protocols to manage people's long term conditions such as dementia and diabetes. Staff contacted permanent resident's GP where necessary and followed the advice of dietitians and district nurses. Staff also contacted the relevant emergency services where people required immediate medical attention.

The home had been purpose built to meet the needs of people with limited mobility. The corridors are wide and doorways are wide enough to accommodate wheelchair access. The home was well maintained so that corridors and communal areas were clutter free and had good lighting. People could maintain their privacy as their bedroom and toilet doors had locks. One person told us "You can please yourself about locking the door, but I don't lock my door."

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 less restrictive as possible. 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 MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

There provider had made suitable DoLS applications to the relevant authorities and were awaiting the assessments or outcomes. The registered manager and staff understood their roles in assessing people's capacity to make decisions. People told us they were asked about consent to care and treatment.

Good

# Is the service caring?

## Our findings

People who lived permanently at Spencer House Care Home on Althorpe and Churchill continued to receive good care from staff who knew them well. They had developed positive relationships over time as they saw the same staff on a regular basis. People told us they were very happy with the care. One person told us "I have a good relationship with the staff."

People told us that staff were kind to them. One person said "If I am tired or start talking to myself, they always help me and check I am ok, my memory is not the same now." Where people had become confused staff assisted them to feel less anxious. For example one person said they were lost; staff very gently talked to them, guided them to their own room and stayed with them for a few minutes until they were settled.

Staff received specific training in the visions and values expected of them. This included how to treat people as individuals, one member of staff told us "Our training taught us how to respect others and provide care as you would wish to be cared for." People were referred to by their preferred name and were acknowledged by staff in passing. People told us they were very well cared for and staff were attentive. One person said "They [staff] pop in and see if I want anything." Where possible staff spent time with people, one person told us "Sometimes they [staff] will have a chat with me."

Nursing staff helped to advocate for people in Blenheim Ward as decisions were made to prepare for people's discharge. For example, one person had been assessed by the physiotherapist for discharge; the nurse had ensured that all the information about their ability to meet their own needs, their mobility and health had been included in their assessment to ensure a safe discharge. The person had initially been upset as they felt they were not able to look after themselves yet. The nurse was able to allay their fears and provide information to the discharge planners to plan further rehabilitation before discharge home.

People received care from staff that preserved their dignity by ensuring that they were discreet in offering personal care and providing this in the privacy of their rooms or bathrooms. One person told us "The girls wash me daily I do not feel embarrassed, they treated me better than a queen; I have never had to complain".

One person told us "They look after you here and I feel relaxed and safe. I keep my door open I don't like being shut in. They treat me with dignity and respect and I get help with showering." We observed staff maintaining people's dignity by changing clothing as soon as it was soiled, for example one person had help to mobilise to their room to change their shirt as some dinner had spilt on to it.

People's visitors were made to feel welcome; they could meet in people's own bedrooms or in communal areas where hot drinks were available. Some people required help with their meals; where visitors had expressed a wish to assist their relatives, they had been made to feel welcome. Otherwise mealtimes had been set aside as protected times from visitors to allow people to eat their meals at their own pace.

There were no restrictions to people being admitted to the home as long as there were staff that could meet

their needs. The provider employed staff from diverse cultures and backgrounds which could reflect people's own backgrounds, sexual orientation or culture. There were policies and procedures in place that were monitored for their effectiveness through audit and supervisions to ensure that people would be treated with dignity and respect no matter their age, sex, race, disability or religious belief.

Good

# Is the service responsive?

## Our findings

People were assessed before they used the service to ensure that the service could meet their individual needs. Staff created people's initial care plans which were updated as their needs changed. One person told us "Staff discuss my care plan with me." People provided information about their lives which helped staff to relate to them; staff talked to people about their interests and their families.

People expressed their likes, dislikes and preferences in their care plans. Staff told us this enabled them to provide care that met people's preferences. For example staff had recorded the times people preferred to get up in the morning and go to bed at night and kitchen staff knew people's food preferences.

Each person's care plan reflected their individual needs which staff followed to provide people's care. The care plans provided specific instructions such as the frequency people were helped to relieve their pressure areas or equipment that was used. One person told us "I have a ripple bed with air but my skin is very fragile and needs creaming by staff and know they need to be careful. I am on steroids which makes my skin thin".

Staff ensured that people maintained their health and well-being by following plans of care. For example one person told us "I have physio four times a week at this home which was necessary to keep my functions going. The staff talk to me and fill me in on the things I can do. They are extremely good."

People who lived permanently at the home had opportunities to take part in activities they found fun and enjoyable. On the day of inspection people were playing carpet bowls and people were laughing and celebrating people's successes. The activities co-ordinator was especially good at relating to people and anticipating their needs. This was one of many regular activities available to people on a daily basis.

People felt confident that they could make a complaint. One person told us "I should say if I was not happy about something." People had the opportunity to raise any concerns informally with staff, senior staff or managers, or formally in writing. One person told us "If I have any concerns I would talk to the main desk and talk to them." One relative told us they felt confident in raising a complaint, they said "We are able to go to [registered manager] with any concerns straight away." The provider had procedures in place to record and respond to people's concerns. Complaints had been responded to in a timely way. Points for learning were shared with staff at team meetings to help prevent future complaints.

People had the opportunity to discuss with staff what it meant to be at the end of life. People had expressed their own preferences in how they wanted their care to be provided when they were at end of life; this was recorded in their records and reviewed as and when people made their preferences known. Staff received training and support from the hospital and community end of life teams.

Good

# Is the service well-led?

## Our findings

There was a registered manager who had managed the home since July 2017. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have 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 and carried out their role of reporting incidents to CQC.

The service had an open culture where staff had the opportunities to share information; this culture encouraged good communication and learning. The deputy manager explained "We continually learn from incidents, we reflect on what we could do differently next time and how staff feel about the incident." Staff told us that the registered manager and senior staff were approachable. One member of staff said "I like working here, it's a privilege. It's a well-run home; the management really do care about the staff."

The provider worked well with the commissioners and the local hospital to provide the step down service for the hospital by admitting people to the home for discharge planning. The provider continually strived to improve the communication and level of service through regular meetings, audits and reflection of the service. The deputy manager demonstrated how the service had evolved through learning from each other; they now had a system where hospital staff (trusted assessors) provided an assessment of people being transferred to Blenheim Ward which enabled Spencer House staff to be permanently based at the home. The provider had identified an issue with the availability of medical staff from the hospital; they were working closely with the hospital to implement a change to the supply of doctors from a local GP practice.

The registered manager ran a resident and relative's focus group to discuss issues raised by people living at the home. The meeting minutes of September 2017 showed that 12 people attended; people were generally happy with the service and made suggestions which the provider was considering, for example the provision of a small shop in the home. The provider sought feedback from people who used the services in September 2016 which showed that most people found the care and service to be good or excellent. The provider was exploring ways of capturing people's feedback about the service through people's reviews and staff feedback.

The provider and manager monitored the service regularly for the quality of the care they provided, for example they carried out audits of training, cleanliness, care records and medicines. The registered manager was proactive in reminding staff about when their training was due through notices and meetings. They also analysed the prevalence and timings of falls to identify when and how people were at high risk. The deputy manager demonstrated how every person admitted to Blenheim Ward had their care records audited for completeness.  Any issues that had been identified had been resolved through actions carried out promptly by the nursing staff.