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Speke Care Home (Residential)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
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

We carried out an unannounced inspection of Speke Care Home on 15 August 2017. Speke Care Home is a purpose built two storey building situated in the Speke area of Liverpool. The home is registered to provide personal care for up to 49 older people and at the time of our visit the service was providing support for 15 people. At the time of inspection everyone was accommodated on the ground floor of the home.

The service had a manager who had been registered with CQC since March 2017. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service was in the process of changing providers and we met the prospective new provider during the inspection.

The service had been placed in special measures following the previous inspections of the home. However, in response to the improvements that had been made we took the home out of special measures.

Staff who administered medication had been medication trained. The majority of medication records were completely legibly and properly signed for, however we found some areas for further improvement.

For the most part, appropriate recruitment processes and checks had been made before new staff started working at the home. However, the references obtained for one new staff member did not match what was on their application form. We also saw that not all induction records had been completed by new staff at the beginning of their employment.

The décor in the home was tired and dated and in need of refurbishment. For example, we saw poor quality curtains and old furniture that needed replacing. It was very hot in some rooms and the registered manager told us that they were not able to adjust the heating or turn off individual radiators.

Each person had an individual care file that contained an assessment of the person's needs. These were written in a person-centred style, however we saw that there was a poor assessment form that was inappropriate and impossible for staff to complete in any meaningful way. Some information was long-winded and repetitive.

The policies for the home were in need of updating to ensure the staff had appropriate guidance for working in the home.

The Mental Capacity Act 2005 and the associated Deprivation of Liberties Safeguards legislation had been adhered to in the home. The provider told us that some people at the home lacked capacity and that a number of Deprivation of Liberty Safeguard (DoLS) applications had been submitted to the Local Authority in relation to people's care. We found that in applying for these safeguards, people's' legal right to consent

to and be involved in any decision making had been respected.

There were enough staff employed at the home to meet people's care needs. The staff were friendly, welcoming and had good relationships with people living in the home and a kind and respectful approach to people's care. The manager was a visible presence in and about the home and it was obvious that she knew the people who lived in the home well.

We spoke with the registered manager and she was open and honest and told us that she was committed to delivering a quality service. One person who lived at the home told us they felt safe at the home. They had no worries or concerns. People's relatives also told us they felt their family members were safe.

Infection control standards at the home were good and standards were monitored and managed. Maintenance records were up to date and legible, this meant the home was a safe environment. The registered manager had systems in place to ensure that people were protected from the risk of harm or abuse. The home had quality assurance processes including audits and satisfaction questionnaires.

People had access to sufficient quantities of nutritious food and drink throughout the day and were given suitable menu choices at each mealtime.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

Medication was not always recorded appropriately.

Safe recruitment procedures had not always been followed.

The home was clean and infection control procedures were in place. Hygiene standards were audited regularly.

Staff had received training about safeguarding people from abuse.

Is the service effective?

Requires Improvement

The service was not always effective

New staff had not always completed an induction process.

The décor in the home was tired and dated and in need of refurbishment. There was poor lighting in some areas and issues with radiators that were too hot.

The registered manager understood and applied the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards and had made appropriate referrals to the local authority.

Is the service caring?

Good

The service was caring

The confidentiality of people's records was maintained.

We observed staff to be caring, respectful and approachable.

Relatives told us there was good communication between the home and themselves.

Is the service responsive?

Requires Improvement

The service was not always responsive

Each person had an individual care plan however documentation was sometimes long winded and repetitive or impossible for staff to complete in any meaningful way.

People had prompt access to healthcare professionals when required.

The complaints procedure was displayed and records showed that complaints were dealt with appropriately and promptly.

Is the service well-led?

Requires Improvement

The service was not always well led

Policies and procedures were in need of updating.

The service had a manager who was registered with the Care Quality Commission.

Quality assurance systems were in place to ensure the service provided safe and good care.

Speke Care Home (Residential)

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 15 August 2017 and was unannounced. The inspection was carried out by two adult social care inspectors.

Prior to the inspection we asked for information from the local authority quality assurance team and we checked the website of Healthwatch for any additional information about the home. 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.

We reviewed the information we already held about the service and any feedback we had received. Before the inspection, the provider completed a Provider Information Return. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with six staff including the registered manager and the cook, two relatives, two visiting health professionals and one person who lived at the home. The people who lived at the home were not able to express their views of the home to us but we saw that they appeared happy and comfortable however we spoke with six relatives.

We looked at the communal areas that people shared in the home and a sample of bedrooms. We reviewed a range of documentation including four care records, medication records, four staff files, policies and procedures, health and safety audits and records relating to the quality checks undertaken by the manager.

We looked around the premises and spent time observing the care and support provided to people throughout the day.

Requires Improvement

Is the service safe?

Our findings

We spoke with people who lived at the home and their relatives and asked if they felt safe. One relative told us "I'm positive [relative] is safe", another person told us "If I had any worries [person] wouldn't be there".

The manager maintained a clear audit trail of any safeguarding incidents, showing what action had been taken to support the person. The required notifications had been sent to CQC. We asked staff members if they knew safeguarding processes and asked if they felt confident to report any type of potential abuse. Records showed that staff had attended safeguarding training. There was information on how to report safeguarding concerns on a noticeboard at the entrance of the home.

We looked at the records for accidents and incidents and saw that actions had been taken following any accidents or incidents; examples of this were referrals being made to the community matron.

We looked at the arrangements for the safe-keeping and safe administration of medication. The registered manager told us that they had recently changed pharmacy and that this had improved the service significantly. The staff authorised to administer medication had undertaken relevant training and we saw medication competency checks recorded for all seniors in January and February 2017. The temperature of the drugs fridge was checked regularly and recorded.

We checked people's medication administration charts. The balance of stock matched what had been administered. This indicated that medication had been given correctly. We saw that protocols were in place for medication that was prescribed to be used 'when required' (PRN), however PRN medication records had not always been completed.

One person was prescribed liquid paracetamol and staff had signed the medication chart daily to record that it had not been required by the person. However we were unable to find any paracetamol for this person. We found a similar situation with another item.

We brought this to the attention of the registered manager who concluded that these medicines had been returned to the pharmacy but this had not been recorded by staff. The manager took prompt action to address this with staff.

We looked at recruitment files for four staff and found that for the most part the appropriate recruitment processes and checks had been made. However the references in place for one new staff member did not match what had been put on their application form. Other checks such as, proof of identity and criminal records checks had been carried out.

The manager carried out monthly infection control audits, the most recent being in June 2017. This identified improvements needed in the laundry. We saw that the laundry was clean and tidy but was in a poor condition with tiles missing off the wall. Staff wore gloves and aprons when assisting with personal care and antibacterial soap was available throughout the home to assist with infection control. The

registered manager told us they brought in additional staff if areas of the home needed to be 'deep cleaned'. We found that the home was clean with no offensive odours.

There were enough staff on duty on the day of the inspection and the rotas we looked at showed that these numbers were maintained consistently.

We looked at safety certificates that demonstrated that utilities and services, including gas, electrics and small appliances had been tested and maintained. We also saw that regular checks had been carried including fire alarms, emergency lighting, lifting equipment, call bells, mattresses, and water temperatures.

A Legionella risk assessment had been carried out in 2015 but there was no record of chlorination. The registered manager told us there were no cold water tanks and the building was all mains fed. However she had identified that they needed to check the cold water for Legionella and had discussed this with the proposed new provider.

Risks to people's safety and well-being had been identified, such as the risks associated with moving and handling, falls, pressure areas and nutrition and plans had been put in place to minimise risk. Examples of the home identifying and minimising risk included people having low beds and crash mats if they were at risk of falling out of bed.

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 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).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met and found that they were. The registered manager had a full understanding of the MCA and its application and people had MCA assessments. We saw evidence in care documents that people who were able to had been involved in discussions regarding their care. This showed that people's legal right to consent to their care had been respected.

The home was set over two floors. The first floor was unoccupied but was clean and tidy throughout. The décor in the home was tired and dated and in need of refurbishment, for example poor quality curtains and shabby old furniture. It was very hot in some rooms and the registered manager told us that they were not able to adjust the heating or turn off individual radiators. One person was in bed with a large fan to try and cool them while a radiator was sending out a lot of heat on the other side of their bed.

The home had good sized bathrooms and shower rooms, a very large lounge and dining room on ground floor and a small lounge on the first floor. The ground floor lounge had different areas for people to sit and there was also a conservatory. The conservatory was used as a smoking room for people living in the home. There were two gardens, however they were not easily accessible for people and they would require the support of staff to go out in the garden. The gardens were enclosed, tidy and had tables and chairs. We looked at some bedrooms with people's permission and saw that they were individualised.

One area of the ground floor that was previously the dementia care unit was in a better condition in terms of décor and had its own dining/kitchen and lounge and plenty of pictures and stimulation for people. This was not in use at the time of inspection. Following the inspection the proposed new provider forwarded their refurbishment plan that showed their plans for improvement throughout the home.

People's weights were monitored frequently if required and medical advice sought if people's dietary intake significantly reduced. People at risk of malnutrition had their dietary intake monitored by staff to ensure that they received enough nutrition to maintain their physical well-being. Staff told us that at present there were no concerns about people's appetite or weight. We spoke with a visiting assistant practitioner for a dietician who informed us that the home made appropriate referrals and that they were very open to suggestion for the benefit of the people living in the home. They said "They [staff] give a good account, the weights are up to date and they tell you exactly how it is".

A white-board in the kitchen showed people's dietary needs. One relative told us that the staff were very good at managing a person's diabetes and had informed the family about inappropriate foods that they were bringing into the home and how this could affect the person's health. The care staff and the cook had a good knowledge of people's needs. We observed that some people needed encouragement with their meals and staff sat with them when they had finished serving.

We looked at four staff files that showed each staff member was meant to complete the provider's induction schedule within the first twelve weeks of employment. Some of these had not been completed and this was brought to the manager's attention. Induction provides the basis of a person's knowledge about the home and working in the care sector. We could not be certain that the staff had been appropriately trained when they first started at Speke Care Home.

Records showed that staff had attended a variety of training that included, equality and diversity, mental capacity, deprivation of liberty, first aid, fire safety, infection control, moving and handling and safeguarding. We saw evidence that the registered manager had implemented a supervision and appraisal system for the staff. Supervision provides staff and their manager with a formal opportunity to discuss their performance, any concerns they have and to plan future training needs.

Good

Is the service caring?

Our findings

We asked relatives and visitors if they thought the staff were caring and they told us "They're all approachable, from the cleaner to the manager" and "They're very good with [relative]". People looked well-groomed and cared for and were dressed appropriately.

We observed staff chatting with people about day to day things and spending time making sure that people's needs were met. There was always at least one member of staff in the lounge and they sat with people. Music was playing on the TV which was age-appropriate for example music from the 1950s. This showed that thought and planning had gone into making the environment pleasant for people living in the home.

We observed staff throughout the day supporting people who lived at the home. Interactions between staff and the people they cared for were positive. All the staff we observed were respectful of people's dignity and supported them at their own pace. We also saw staff addressing people in the manner they preferred. One relative told us that "[Person] trusts the lot of them, they love her".

Staff engaged with people and visitors in a warm and friendly manner. Each relative we spoke to told us that the staff were welcoming and that they could visit at any time.

We observed that confidential information was kept secure either in the offices or medication room. This protected people's right to confidentiality.

No one living in the home was receiving end of life care at the time of inspection, however the registered manager had completed a one year course for end of life care and told us some staff were currently doing end of life care training. The home had also nominated an end of life champion from the staff team. This meant that the home had staff who would be able to care for people appropriately when needed.

We asked relatives if there was good communication with the home and the majority of responses were positive. One relative told us "If there's a problem they keep me informed." Another relative told us "Yes, I've a good relationship with them".

The home did not have a current service user guide available. This is a document that provides information about the services provided for people coming into the home. The registered manager and the proposed new provider said they were planning to write a new service user guide.

We looked in the entrance area for any information about the home and saw that there was information about how to make a complaint, safeguarding and information about staff who were dignity champions. A dignity champion is someone who believes that being treated with dignity is a basic human right, not an optional extra. We saw that the home had a staff board in the entrance hall with names and photographs of staff.

Requires Improvement

Is the service responsive?

Our findings

Individual care files were in place for people living at the home. Care files contained an assessment of the person's needs. These were written in a person-centred style, in the first person and contained a detailed life history of the individual. Care plans contained information about how the person needed to be supported. This included care plans for communication, mobility, support to make decisions, sleeping, and medication. These had been reviewed regularly and the registered manager told us that all seniors were currently doing care planning training.

In all files we looked at there was a poor assessment form that was inappropriate and impossible for staff to complete in any meaningful way. The registered manager told us that they had previously been told to fill these in but they were not useful and were to be discontinued.

The staff completed 'room records' that contained monitoring information including personal care given, bowel record, nutrition record, fluids record, seizure monitoring and falls logs. These were well completed and there were also records of night staff two hourly checks. This meant that families could look at them for example to see what people have eaten and drunk.

People had prompt access to medical and other healthcare support as and when needed. There were documented visits from district nurses, dieticians and GPs. A person who had started to lose weight was referred to a dietician.

We asked people if they felt comfortable raising concerns or complaints. One relative told us "Yes but I haven't got any complaints." Another relative told us "If I had a problem I'd go straight to the manager".

The complaints procedure and complaints forms were available in the entrance hall. However the complaints procedure did not have telephone or email contact details for the manager or provider. Complaints records were kept and showed that complaints had been dealt with appropriately.

During the afternoon, the senior carer on duty was doing some gentle arm-chair exercises with people in the lounge and people kicked a large ball around. The registered manager and the proposed new provider showed us an activities improvement plan that was due to be implemented. We asked relatives if any activities were carried out with people living in the home and we were told of outings that had been arranged. One relative told us "It's hard sometimes, I've seen them (staff) trying even with people who don't want to know". We spoke with staff who told us that they did activities in the afternoon, for example playing bingo, singing and dancing. Staff showed great commitment to the home and told us about how they brought things in for people and bought things out of their own money.

A hairdresser attended the home weekly. People's spiritual needs were respected as the home had arranged for regular visits from church representatives.

Requires Improvement

Is the service well-led?

Our findings

The home had a registered manager who had been in post since March 2017. The registered manager understood their responsibilities in relation to the service and registration with CQC and regularly updated us with notifications and other information. We spent time talking to the registered manager and the prospective new provider. We saw that the new provider was already working in the home, supporting the manager and making improvements. We also saw that they had made applications to CQC to become the registered provider of the service. They told us how committed they were to providing a quality service. The manager was very committed to the service and had lots of ideas about how she would like to redevelop the service. She was working closely with the prospective new provider. She was dynamic and energetic and very positive about the future of the home and had worked in care for many years.

Staff had access to policies and procedures on areas of practice such as advocacy, restraint, safeguarding, whistle blowing and safe handling of medicines. However, these were in need of updating. The registered manager and the prospective new provider told us about their plans to review and update each policy so that staff would have up to date guidance. Staff and the registered manager shared information in a variety of ways, such as face to face, during handovers between shifts and in team meetings.

We saw records of team meetings that had been held in February 2017 for the whole staff group. These showed that staff were able to express their views and any concerns they had. We did not see any evidence of residents meeting however we did see feedback from a satisfaction survey 2017. This was displayed on a noticeboard and the registered manager said this had been more positive than the previous one. We saw that 15 survey forms had been returned and contained many positive responses. Where a negative score had been made, this was only by one respondent in any given area so there was no trend of people being dissatisfied with any particular aspect of the service.

However, we considered that the survey form was not very good. It gave people little space to make a comment and a lot of forms looked like they had been filled in with help from staff.

The registered manager regularly monitored the quality of care at the home through audits of health and safety, medication, infection control and care plans. We saw that monthly medication audits had been recorded up to June 2017 with no issues identified. The registered manager told us she had varied the frequency of the audits as nothing much changed at the home, However following the feedback from inspectors during the inspection, she intended to audit medication weekly. The quality assurance process also contained the registered manager's observations of care including hand hygiene and meals service.

From April 2015, providers must clearly display their CQC ratings. This is to make sure the public see the ratings, and they are accessible to all of the people who use their services. The provider was displaying their ratings appropriately in a clear and accessible format at the entrance to the home.

Staff we spoke to felt supported and well trained and one staff member commented "[Name] is a great manager, she is firm but fair". Another staff member said that training had helped them interact with the

people living in the home more effectively. They said "You need to know how to speak to residents".

Relatives we spoke to knew who the registered manager was and they felt she was approachable and had no hesitation in speaking to her if they had any problems.