Care Quality Commission

Bupa Care Homes (ANS) Limited

Maypole Care Home

Inspection report

Lower Northam Road
Hedge End
Southampton
Hampshire
SO30 4FS

Tel: 01489782698

Date of inspection visit:
17 July 2017
18 July 2017

Date of publication:
10 August 2017

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

The inspection took place on the 17 and 18 July 2017 and was unannounced.

Maypole Care Home provides accommodation and nursing care for up to 68 older people, some of whom may have mental health needs or have a physical disability. At the time of our inspection 64 people were living at the home.

The service had a registered manager. 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.

There were sufficient numbers of staff deployed to meet people's individual needs. New staff had been employed following robust recruitment and selection procedures and this ensured that only people considered suitable to work with vulnerable people were working at the home.

Since our previous inspection we found improvements had been made in relation to staff training, support and supervision.

People received end of life care to a good standard and the staff had strong working relationships with external healthcare professionals.

People told us that they felt safe living at the home. People were protected from the risks of harm or abuse because there were effective systems in place to manage any safeguarding concerns.

The registered manager, care staff and nursing staff were trained in safeguarding adults from abuse and understood their responsibilities in respect of protecting people from the risk of harm.

Staff were supported by the registered provider and registered manager, and felt that they were valued.

Staff had received induction training when they were new in post and told us they were happy with the training provided for them.

Medicines were stored, recorded and administered safely.

People told us that staff were caring and that their privacy and dignity was respected. They said that they received the support they required from staff.

People's nutritional needs had been assessed and people told us they were very happy with the food provided. People's individual food and drink requirements were met.

Complaints made to the home had been thoroughly investigated and people had been provided with details of the investigation and outcome.

There were systems in place to seek feedback from people who lived at the home, relatives and staff.

People were supported to participate in a variety of activities.

Staff, people who lived at the home, relatives and a social care professional told us that the home was well managed. Quality audits undertaken by the registered provider and registered manager were designed to identify any areas of improvement to staff practice that would promote people's safety.

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 remains safe. The provider had sufficient numbers of suitably qualified staff on shift at all times.

Staff received safeguarding training and knew what to do if concerns regarding a person's safety were raised. Robust recruitment procedures ensured that only suitable staff were employed.

Risks to people were well managed.

People's medicines were safely managed.

Is the service effective?

Good

The service was effective. People were supported with their healthcare needs, including receiving attention from GPs and routine healthcare checks. Assessments had been completed on people's physical health, medical histories and psychological wellbeing.

Staff had extensive knowledge, skills and experience to meet people's needs effectively. Staff received excellent support and supervision, and benefitted from regular training.

People's rights were respected. People who lacked capacity to give consent to their care were protected by the Mental Capacity Act (2005).

Is the service caring?

Good

The service remains caring. Good arrangements were in place for end of life care.

Staff were familiar with people's needs and knew them well.

Interactions between people and staff were positive, dignified and respectful.

Is the service responsive?

Good

The service remains responsive. The service provided exceptional

person-centred care tailored to people's needs, wishes and preferences.

People's care needs were fully assessed and detailed and care plans were in place to direct their care.

Robust systems were in place to deal with any complaints received.

Is the service well-led?

Good

The service remains well led. The registered manager and the provider had good relationships with professionals.

People, their relatives and professionals were regularly asked for their feedback and this information was used to help improve the service.

Good leadership was seen at all levels. Relatives told us the senior staff and the registered manager was approachable and took any concerns raised seriously.

Care Quality Commission

Maypole 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 inspection took place on 17 and 18 July and was unannounced.

The inspection team consisted of two inspectors.

Before our inspection we reviewed previous inspection reports and notifications we had received. A notification is information about important events which the provider is required to tell us about by law.

During our inspection we spoke with the registered manager, the clinical service manager, 12 members of staff, 12 people and eight relatives. After the inspection we obtained feedback from five healthcare professionals.

We pathway tracked four people using the service. This is when we follow a person's experience through the service and get their views on the care they received. This allows us to capture information about a sample of people receiving care or treatment. We looked at staff duty rosters, four staff recruitment files, feedback questionnaires from relatives

We last inspected the home on 18, 19 and 24 February 2015 and rated the service as good. We found improvement was required in relation to staff training, support and supervision.

Good

Is the service safe?

Our findings

The service remains safe. Relatives and healthcare professionals told us robust arrangements were in place to keep people safe. A relative said, "There are always enough staff here, I visit all the time and it's not something I have ever been concerned about". A healthcare professional said, "Anytime the staff have had concerns they have called us and we have spoken about it, I am happy with how they assess any risks".

The service had taken appropriate steps to protect people from the risk of abuse. Staff were aware of their responsibilities in relation to safeguarding. They were able to describe the different types of abuse and what might indicate that abuse was taking place. Staff told us there were safeguarding policies and procedures in place, which provided them with guidance on the actions to take if they identified any abuse. They told us the process that they would follow for reporting any concerns and the outside agencies they could contact if they needed to.

Risk assessments were in place for all people living at the home. Staff told us that, where risks were identified measures were put in place to ensure the risk was safely managed. For example, people who were cared for in bed had easy and direct access to an alarm call bell. The level and frequency of observations of these people by staff were increased accordingly. We saw from the staff observation records that these welfare checks had been made frequently and were recorded accurately and in a timely manner.

Safe recruitment processes were in place. Staff files contained all of the information required under Schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Application forms had been completed and recorded the applicant's employment history, the names of two employment referees and any relevant training. There was also a statement that confirmed the person did not have any criminal convictions that might make them unsuitable for the post. A Disclosure and Barring Service (DBS) check had been obtained by the provider before people commenced work at the home. The Disclosure and Barring Service carry out checks on individuals who intend to work with vulnerable children and adults, to help employers make safer recruitment decisions. Checks to confirm qualified nursing staff were correctly registered with the Nursing and Midwifery Council (NMC) were also held on file. All nurses and midwives who practice in the UK must be on the NMC register.

There were enough skilled staff deployed to support people and meet their needs. During the day we observed staff providing care and one-to-one for support for people at different times. Staff were not rushed when providing personal care and people's care needs and their planned daily activities were attended to in a timely manner. Staffing levels had been determined by assessing people's level of dependency and staffing hours had been allocated according to the individual needs of people. Staffing levels were kept under review and adjusted based on people's changing needs. Staff told us there were enough of them to meet people's needs. People said call bells were answered promptly and staff responded quickly when they rang for help. People who were unable to use this system were checked by staff at regular intervals to ensure their safety but also monitor their needs.

Equipment used to support people with their mobility needs, including hoists, had been serviced to ensure

they were safe to use and fit for purpose. Staff had received training in moving and handling, including using equipment to assist people to mobilise. One staff member told us it was important to know how to move people safely and they felt confident that they and their colleagues were fully competent with this.

There was a clear medication policy and procedure in place to guide staff on obtaining, recording, handling, using, safe-keeping, dispensing, safe administration and disposal of medicines. People's medicine was stored securely in medicine cabinet's that were secured to the wall within two locked treatment rooms. Medicines that were required to be kept cool were stored in an appropriate locked refrigerator and temperatures were monitored and recorded daily. Regular checks and audits had been carried out by the registered manager to make sure that medicines were given and recorded correctly. Medication administration records were appropriately completed and staff had signed to show that people had been given their medicines.

The premises were being maintained in a safe condition. There were current maintenance certificates in place for gas safety, the electrical installation, the passenger lift, mobility hoists, bath hoists, portable appliances, the fire alarm system, emergency lighting and fire extinguishers. There was a fire risk assessment in place and fire drills were taking place at regular intervals. The home carried out a weekly fire test including checks on the fire alarm system, emergency lights, fire doors, fire extinguishers and exit routes. This helped to make sure the fire safety arrangements in place at the home were robust.

Good

Is the service effective?

Our findings

Staff told us they were supported in the role. One member of staff said; "I have had a few supervisions since I have started and I had lots of training. I am shadowing at the moment and I am learning a lot".

The provider had made improvements in relation to staff training and supervision since our previous inspection. Staff were supported in their role and had been through the provider's own induction programme. This involved attending training sessions and shadowing other staff. The induction programme embraced the 15 standards that are set out in the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life.

There was an on-going programme of development to make sure that all staff were up to date with required training subjects. These included health and safety, fire awareness, moving and handling, emergency first aid, infection control, safeguarding, and food hygiene. Specialist training had been provided to staff where additional knowledge was required in areas of Parkinson's, dementia and mental health. This meant that staff had the training and specialist skills and knowledge that they needed to support people effectively.

There was a consistent approach to supervision and appraisal. Supervision and appraisal are processes which offer support, assurances and learning to help staff development. Staff received regular one to one supervision, annual appraisal and on-going support from the registered manager. This provided staff with the opportunity to discuss their responsibilities and the care of people living at the home. Records of supervisions detailed discussions and there were plans in place to schedule appointments for the supervision meetings. Staff had annual appraisals of their work performance and a formal opportunity to review their training and development needs.

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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People's mental capacity had been assessed and taken into consideration when planning their care needs. The MCA contains five key principles that must be followed when assessing people's capacity to make decisions. Staff were knowledgeable about the requirements of the Act and told us they gained consent from people before they provided personal care. Staff were able to describe the principles of the Act and tell us the times when a best interest decision may be appropriate.

Where family members had the legal rights to make decisions regarding the care of their relative documents were held at the home to evidence this such as, Power of Attorney (PoA). A PoA is a written document that gives someone else legal authority to make decisions on your behalf. Copies of those documents where relevant were kept in people's personal records which were kept securely in the administration office.

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. Some people were unable to understand risks to their safety and that they were not safe to go out without support from staff. Appropriate applications had been submitted to ensure that people were only deprived of their liberty when it was necessary to protect them from harm. The provider was complying with the requirements of the MCA and DoLS.

People's care plans showed they were involved in decisions about their care and treatment. Their consent had been discussed and agreed in a range of areas including receiving medicines and support. Staff were knowledgeable about the importance of obtaining people's consent regarding their care and treatment in other areas of their lives.

People who had been identified as being at risk of choking, malnutrition and dehydration had been assessed and supported to ensure they had sufficient amounts of food and drink. Nutritional risk assessments were carried out and where appropriate food and fluid intake was monitored and recorded. A member of staff told us a malnutrition universal screening tool (MUST) was used to identify people who may be underweight or at risk of malnutrition. Any risks identified such as weight loss were shared with relevant professionals such as their GP or a dietician. People were provided with choice about what they wanted to eat and people told us the food was of good nutritional quality and well balanced. The chef offered a menu that took account of people's preferences, dietary requirements and allergies.

Arrangements were in place for people's healthcare needs to be monitored through a regular review process. Care records demonstrated people had received visits from health care professionals, such as doctors, chiropodists and opticians.

Good

Is the service caring?

Our findings

The service remains caring. Relatives and healthcare professionals consistently told us people received good care. One person said, "I am really happy with the staff, they help me to go to the toilet and if I want something to eat or drink they get it for me". A relative told us staff frequently encouraged people to participate in various activities. They said, "There are always coming in and asking mum if she wants to take part but mum just isn't interested but it is nice they still ask her".

The registered manager and staff shared a passion in providing high quality end of life care. The home was committed to providing end of life care that met people's needs and preferences. Staff told us how people's wishes regarding their end of life care were known as well as their decisions about resuscitation. For people who were unable to make a decision about this appropriate people were involved, for example relatives and GP's. Do Not Attempt Resuscitation (DNAR) forms were in place to ensure people's wishes were known in the event of an emergency.

Each person's physical, medical and social needs had been assessed before they moved into the home and communicated to staff. Pre-admission assessment of needs included information about people's likes, dislikes and preferences about how their care was to be provided. Care plans also included a 'life diary' which documented people's upbringing, early life, education, teenage years, career and work, social and recreational interests and personal achievements. Care plans were developed and maintained about every aspect of people's care and were centred on individual needs and requirements. This ensured that the staff were knowledgeable about the person and their individual needs.

To improve the quality of care people received the registered manager had introduced lead and champion roles for staff. These included, an infection control champion, a nutritional link nurse, a pain link nurse, a tissue viability link nurse and a palliative care link nurse. The registered manger told us whilst specific staff were taking a lead on certain subjects all staff would be expected to deliver high quality care in all areas. The registered manger told us the introduction of lead roles would help people receive higher quality of care because staff knowledge would increase.

We observed respectful and caring interactions between staff and people on in all areas of the home. The staff took care to ensure people received the support they requested and went out of their way to spend time with people. Overall staff showed an interest in people as individuals and asked their opinions about events in the news and other topical issues. They also asked them about important events in their lives and seemed genuinely interested in people's responses. When staff were available they were quick to respond to people's requests and the staff we observed had a gentle and pleasant manner.

Good

Is the service responsive?

Our findings

The service remains responsive. Healthcare professionals and relatives consistently told us staff were responsive to people's care needs. One healthcare professional said, "They (Staff) respond to people's call bells in good time and they seem to know people pretty well". One person said, "I like the activities, there was a pub quiz the other day". A relative said, "(Person's) nursing needs are met well. They change her pad, reposition her and check her blood levels".

Care plans described what support was needed in sufficient detail to ensure that consistent care was provided. People's preferences were detailed, such as, whether they preferred a shower or a bath and how they liked to take their tea. Staff knew people well and understood what preferences they had and this helped to ensure people received the support they wanted. Records showed and staff described how people at times refused care, for example if they did not wish to be helped to wash and dress at a particular time and staff said this was respected. They would return at a later time to support them instead.

People's individual assessments and care plans were reviewed with their participation or their representatives' involvement. Care plans had been updated to reflect any changes to ensure continuity of their care and support. Updates had been made when people's medicines or health needs had changed. One relative said, "We had a review not so long ago where we had to change (Person's) medication. We all sat together and had the meeting and afterwards I see the care plan was updated".

Information about people's diagnosed conditions or illnesses and preferences were incorporated into an individual plan of care. Topics covered in care plans included eating and drinking, continence, mobility, personal hygiene / dressing, skin care / pressure relief, health needs (including medication), communication, pain, end of life care and social activities.

The registered manager and staff responded appropriately to people's changing needs. For example, we saw that, where someone's general health had deteriorated over time, their increased care needs had been regularly updated in their care plan. Staff told us that the registered manager kept them updated about any changes in needs of the people using the service. Staff had a good understanding of the current needs and preferences of people at the home.

We looked at how information was handed over from shift to shift within the service. We saw that 'handovers' were thorough and contained relevant information to ensure that people were cared for consistently throughout the day and night. Handover provided staff with the opportunity to share information about risk, appointments, medical concerns or changes in activities.

Activities took place regularly. A relative said, "There is generally always something going on in the home. Today is lovely so I have seen lots of residents relaxing in the garden with their relatives enjoying the sun". People told us activities included animal therapy, quizzes and trips out to local centres such as the garden centre. We observed relatives were able to visit the home without restriction and were a valuable part of the homes support network.

People's rooms were personalised and furnished with their belongings, such as their own furniture, photographs and ornaments. The home worked with people and their relatives to ensure they felt at home as much as possible.

The registered manager and the provider remained responsive in relation to any concerns or complaints raised. Relatives and people consistently told us any issues were taken seriously by the registered manager and dealt with appropriately.

Good

Is the service well-led?

Our findings

The service remains well led. Staff, healthcare professionals, relatives and people were extremely complimentary about the registered manager and the culture they created within the home. A member of staff said, "She (Registered manager) is just brilliant, she is always here helping us out and she is very open and approachable". A relative said, "In all the time (Person) has been living here this is the best it's ever been".

There were systems in place to review the quality of service in the home. Daily, weekly and monthly audits were carried out to monitor areas such as health and safety, care plans, accidents and incidents, and medication. Staff told us there was good communication within the team and they worked well together. Staff, people and relatives told us the registered manager was an extremely visible leader who created a warm, supportive and non-judgemental environment in which people had clearly thrived. Unannounced night visits by the registered manager were undertaken. This looked at the security of the home, cleanliness and documentation. The registered manager told us they had been impressed with their findings during the night visits and said: "Each visit I done at night was positive, there was nothing that concerned me". The home had a clear management structure in place led by an effective registered manager who understood the aims of the service. The registered manager was supported by the organisation that carried out an extensive programme of quality assurance audits. Records showed that the provider's representative visited the service regularly to carry out quality assurance audits, including checking that care and personnel files were up to date and had been reviewed regularly.

We asked staff about whistleblowing. Whistleblowing is a term used when staff alert the service or outside agencies when they are concerned about other staff's care practice. Staff said they would feel confident raising any concerns with the registered manager. They also said they would feel comfortable raising concerns with outside agencies such as the Care Quality Commission (CQC), if they felt their concerns had been ignored. Comments from staff included "I would call CQC or the police" and "I would speak to my manager and CQC if I really needed". Relatives consistently told us they had no concerns of worries about the quality of care provided. Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. The registered manager had informed CQC of significant events in a timely way by submitting the required 'notifications'. This meant we could check that appropriate action had been taken.

There was an open culture where people had confidence to ask questions about their care and were encouraged to participate in conversations with staff. Staff interacted with people positively, displaying understanding, kindness and sensitivity. For example, we observed one member of staff smiling and laughing with one person when playing games. The person responded positively by smiling and laughing back. These staff behaviours were consistently observed throughout our inspection. Staff spoke to people in a kind and friendly way. We saw many positive interactions between the staff and people who lived in the home. During lunchtime we saw a member of staff laughing and joking with one person whilst talking with them about the various jobs they had, the different countries they visited and experiences they had during the war.

To ensure people's voice was heard and relatives were involved in developing the home, Maypole had a very active relatives group who met frequently. Actions were detailed within the homes improvement plan and included the development of a sanctuary room to support relatives and visitors, various fundraising events and ways in which people's documentation could become more person centred.