Society of Christ (GB)

Dom Polski Residential Care Home

Inspection report

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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

Overall summary

We carried out an unannounced inspection of this service on 21 October 2014. When we last inspected the service in June 2013 we found that the provider had not taken proper steps to give written guidance to staff on how to protect people with swallowing difficulties from the risk of choking. Following that inspection the provider sent us an action plan to tell us the improvements they were going to make. They said their improvements would be completed by 31 August 2013. During this inspection we found that satisfactory improvements had been made to protect people who used the service from choking.

Dom Polski is a care home providing accommodation, personal care and support for 14 older people. The home provides a service for older people whose first language is Polish and is owned and operated by the Fathers Of The

Summary of findings

Society of Christ (Great Britain); a Polish religious organisation and a registered charity. The Polish language, culture and traditions are upheld within the home. There were 12 people using this service at the time of our visit.

There was a registered manager in post at the time of this inspection. 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.

Support Staff were confident in describing the different kinds of abuse and the signs and symptoms that would suggest a person they supported might be at risk of abuse. They knew what action to take to safeguard people from harm

A robust system was in place to identify and assess the risks associated with providing care and support. A relative told us and care records confirmed, that risks had been discussed with them and action agreed to keep people safe from accidental harm.

Staff working in the home understood the needs of the people they supported. They supported people in making choices and their own decisions as much as possible. Four people living in the home and a relative told us they were happy with the care provided.

People who used this service received safe care and support from a trained and skilled team of staff. The induction of new staff was robust and they received regular support and mentoring from more senior staff following their appointment. This had been supplemented by further training to equip staff with specific skills, which enabled them to provide person-centred care to people who used the service. Staff fully understood their caring responsibilities and they demonstrated respect for the rights of the people they supported.

During our visit we saw examples of staff treating people with respect and dignity. People using the service and their relatives were consulted and involved in assessments, care planning and the development of the service.

We saw evidence that many aspects of the care and support were based on best practice guidance, such as the recent appointment of infection control champions, whose responsibility was to ensure high standards were maintained by the staff team.

The registered manager had developed an effective system of quality assurance, which measured the outcomes of service provision. Staff, and relatives had been included in this process and their feedback had been used to make improvements to the way the service was provided.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Staff we spoke with knew how to keep people safe from abuse. Staff had access to procedures and supporting documents to guide them on taking the correct action if they suspected a person they supported was at risk of harm.

People who used the service and their representatives had been consulted about risk. Risk management strategies were robust in keeping people safe from accidental harm.

People using this service received safe support to take their medicines as directed by their GPs.

Good

Is the service effective?
The service was effective.

People using this service and their representatives were involved in decisions about how their care and support would be provided and no unnecessary restrictions were imposed on their choices or personal freedom.

People who used this service were supported by trained staff who understood their individual needs well.

Effective systems were in place to monitor people's health and welfare and staff made prompt referrals to health and social care professionals when necessary.

Good

Is the service caring?
The service was caring.

People who used this service were treated with kindness and compassion and their rights to privacy, dignity and respect were upheld.

Care staff listened to the views and preferences of the people they cared for and this was reflected in a person centred approach to the provision of care.

Care staff understood the specific care needs and cultural diversity of the people they supported.

Good

Is the service responsive?
The service was responsive.

People were encouraged to express their views on how their care and support would be provided.

People received flexible support and the equipment they needed to maintain their independence.

People using this service could be confident that their concerns would be listened to and dealt with appropriately.

Good

Is the service well-led?
The service was well led.

Good

Summary of findings

Staff received good support from management, were treated with fairness and worked in an open and transparent culture.

Management and staff had a good understanding of their responsibilities and worked well together as a team.

The systems in place for quality assurance were effective in driving continuous improvement in the best interests of people who used the service.

Dom Polski Residential 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 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 21 October 2014 and was unannounced.

The inspection team consisted of one inspector and an Expert by Experience, who had experience of older people's care services. 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 the inspection we sent the provider a Provider Information Return (PIR). 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. We asked the registered manager why the PIR had not been completed and returned to us and they told us they had not received it. It transpired that the provider had changed their email address, but had not notified the Care Quality Commission.

Before our inspection, we reviewed the information we held about the home, which included incident notifications the service had sent us. During our visit we spoke with four people who were using the service, a relative, two care assistants, a senior care assistant, the registered manager and a GP. We observed care and support in the lounge and dining room and also looked at the kitchen, the laundry and several people's bedrooms. We reviewed a range of records about people's care and how the home was managed. These included care plans and medication records belonging to three people, staff training and supervision records and the quality assurance audits that the registered manager had completed.

Following our visit we received feedback on the quality of the service from the local authority contracts officer and a health professional who visits the home on a regular basis.

Good

Is the service safe?

Our findings

Two members of staff told us they had received safeguarding training and this was confirmed by information we saw in training records. They had a good understanding of the different types of abuse and described the action they would take to keep people safe from harm. Both staff said they would report any concerns to their line managers immediately.

We saw that suitable policies and procedures were in place to guide staff on the action they must take if it was suspected or alleged that people using the service were at risk of abuse. Staff knew how to access this information and the contact details for reporting abuse.

There was written evidence that staff were supported to explore safeguarding issues within their one to one supervision sessions and at team meetings. Staff and the manager had watched a DVD together on safeguarding and abuse. Following this activity they then had a group discussion about what was going on in the video and what might have led staff to behave the way they did. This encouraged staff to analyse interactions between themselves and the people they cared for and to instil the values needed to deliver safe and appropriate care and support.

People using the service had been provided with the information they needed to understand what keeping safe meant. This information was contained in the home's service user guide, which had been issued to people using this service and their representatives. The service user guide informed people how to raise concerns about their personal safety.

Three staff told us, and rotas confirmed, that sufficient staff were deployed to meet the assessed needs of the 12 people living in the home. We saw that staff numbers had been increased at busy times, such as mealtimes, and from November 2013 an extra care assistant had been deployed during the night. The registered manager explained that this was done to make sure staff had sufficient resources to meet people's nutrition and moving and handling needs safely.

Information held in staff records confirmed that the required pre-employment checks had been undertaken prior to confirming that staff were suitable to work with older people.

We saw a hazards risk assessment had been carried out in May 2014. This document identified risks in the environment and how they would be managed to keep people living and working in the home safe from accidental injury. Some of the areas covered were slips, trips and falls, fire safety, burns and scalds, the storage of inflammables and substances hazardous to health and spillages. Robust plans to manage safety in the environment had been written down and shared with the staff team. This meant that staff had clear instructions on what they must do to protect people from accidental injury.

Plans were also in place for responding to emergencies or untoward events, such as outbreaks of infection, fire, flood and the failure of equipment used in the home. Risks of system and equipment failure had been minimised by a programme of servicing and maintenance of equipment. For example, we saw that relevant contracts were in place for gas safety, portable appliance testing, emergency lighting and clinical waste removal.

A system was in place to record accidents and incidents, such as falls. The registered manager told us that the outcome of accidents and incidents were analysed to see what lessons could be learnt and reduce future risk by taking preventative action. Accident records showed that care staff monitored people for three days after a fall, after which the registered manager had reviewed the evidence to see if any further action was needed.

The two care records we looked at contained appropriate risk assessments and risk management plans and we saw that risks had been discussed with either the person or their relative. A relative we spoke with confirmed that they had been involved in decisions made about managing risk. We saw detailed guidance provided for staff to follow in three risk management plans. The written information guided staff on the safe use of a manual hoist, tracking hoist and the use of bed rails. The three care records confirmed that a robust risk assessment and management strategy was being followed to keep people safe from accidental harm.

We looked at nutritional risk assessments contained in two of the care records. These records showed that nutritional risk was being monitored and that people living in the home had been weighed each month. Where concerns over weight loss had been identified, prompt referrals had been made to dietitians.

Good

Is the service safe?

The manager told us that senior care assistants were trained in the administration of medication and this was confirmed in the training records we saw and in conversation with two senior staff. Medication was safely and securely stored in a locked cupboard. Medication administration records (MAR) showed that the people accommodated in the home had received their medicines as directed by their GPs. Detailed protocols had been written down to guide staff in safely administering occasional medicines, such as pain killers.

The registered manager told us none of the people accommodated were administering their own medication at the time of our visit. They added that people given this option would be risk assessed to make sure it was safe for them to look after their own medication needs.

Good

Is the service effective?

Our findings

We looked at staff training records and these provided evidence that staff received induction and ongoing training to develop the skills and knowledge needed to meet the needs of people using this service. The registered manager told us that new staff underwent a two week induction, during which time they were assigned a buddy for support and shadowed an experienced member of staff during their shifts. Three staff told us they were currently studying for a level two or three qualification in Health and Social Care. One member of staff said, "The manager has arranged regular training and we can ask for more if we think we need it." Another member of staff told us they had been trained in end of life care. They said this enabled them to provide compassionate and dignified care and support in a consistent way.

The manager provided evidence of the service's training and development plan. The manager had assessed each member of staff's strengths and needs to determine the training required in developing the relevant skills and knowledge to meet people's needs. We saw that planned training had been designed to cover the specific care and support needs of people who were using this service.

The manager had developed good links with organisations providing sector specific guidance and training. We were shown several good practice documents, which had been downloaded from organisations such as the Royal Pharmaceutical Society and the National Institute for Clinical Excellence. The manager told us they keep up to date with current best practice by reading care sector magazines and obtaining advice from health and social care professionals.

Since our last inspection of this home, two staff had attended an advanced course in infection control. This provided them with the required expertise to take the lead in assessing hygiene and cleanliness within the home and advising the rest of the team in current best practice. The registered manager also showed us evidence of how they were implementing a system to assess the competency of staff to make sure their performance was meeting specific guidance on best practice in the delivery of care.

During our observations of interactions between staff and people living in the home, we saw that staff communicated with people in their first language. Staff were also proficient at communicating with people in English where this was their preference. A visiting professional told us that staff working in the home were effective at communicating with them. They said that the staff always followed their guidance and had a good understanding of spoken and written English.

We discussed the Deprivation of Liberty Safeguards (DoLS) with the registered manager. They told us that no applications for DoLS authorisations had been made, because each person currently using the service either had the capacity to consent to their care or there was a Lasting Power of Attorney in place. This was confirmed in the three care plans we looked at. The manager had received training on the Mental Capacity Act and DoLS in her previous employment, although she had booked on a refresher course being provided by the local authority in November 2014. The registered manager and care staff we spoke with understood their responsibilities under mental capacity legislation. Care staff confidently described how they supported people to make choices and take decisions and they knew what action to take in the person's best interests, when an individual lacked the capacity to consent to their care and support.

At our last inspection we found that care plans did not contain sufficient information to guide staff on preparing thickened fluids to the correct consistency. This placed people with swallowing difficulties at risk of choking if their fluids were incorrectly thickened. The registered manager showed us evidence of the improvements made since our last visit. The nutrition care plan we saw, provided staff with detailed information on thickening fluids to the correct consistency, as recommended by the Speech and Language therapist. One of the care staff told us they were confident that the improvements had been effective in protecting people from the risk of choking.

Four people expressed satisfaction with the food and drink provided in the home. Two people commented, "I have no complaints about the food" and "The food here is nice."

A relative told us that people were provided with a Polish cultural diet and this was confirmed by the menus we saw. The relative said this was appropriate to the person's needs, although they would have liked to see more lamb on the menu, because this was their relative's favourite meat. They said, "The food is good, but I think there is too much chicken and pork. My relative loves lamb, but it's not provided much." The registered manager told us the menus

Good

Is the service effective?

were currently being reviewed and people would be asked for suggestions of the meals they would like to see on the menu. She confirmed that relatives would also be consulted.

We spoke with a GP who was visiting the home during our inspection. They explained that they were undertaking a new system by visiting the home each week to review their patients. The aim was to provide early intervention of diagnosis and treatment, to prevent the need for people to be admitted to hospital. We asked the GP their views on the quality of care provided in the home. They said, "The manager and staff have a true sense of ownership of their responsibilities to the people living here. They understand the complexity of people's needs and they follow advice to the letter. This home is as good as it gets."

Good

Is the service caring?

Our findings

During our visit we observed interactions between staff and the people they were supporting. Staff addressed people by their preferred names when speaking with them. We saw staff treat people in a kind, caring and compassionate manner and staff responded promptly to people's need for support. We observed staff engaging in meaningful conversations with people. For example, during the morning, a member of staff was sitting with three people at a table in the lounge engaged in conversation. The other people living in the home were sitting either in armchairs or wheelchairs and some were watching the television. We noted that two other staff members were coming into the lounge intermittently and talking or attending to the people in a friendly and polite manner.

Two of the staff we spoke with told us how they cared for people in a private and dignified way. They said they always knocked on bedroom and bathroom doors before entering and that personal care was provided in private. During the lunchtime period we observed that staff discretely consulted people about their care and support needs.

From the conversations we had with three staff it was evident that they understood the specific care needs and cultural diversity of the people they supported. The staff gave examples which demonstrated how they met people's diverse needs in a caring and respectful manner, for example by supporting people to attend religious services of their choice, follow their choice of cultural diet and celebrate religious festivals. The registered manager told us that a troupe of Polish dancers regularly came into the home to entertain people.

The four people we spoke with during our visit confirmed that their care was provided in a respectful and dignified manner. They said staff understood their needs and provided support in a timely manner. One person commented, "I feel very well cared for here and the staff do listen to me." This person also said they were very contented with life. A second person said, "I am very comfortable here and I have no problem with the staff."

The relative we spoke with said that staff respected people and maintained their privacy and dignity. They said, "The staff are always respectful and provide all the care that is needed. They will contact me if they have any worries about my relative." They told us that there were no restrictions on visiting hours and that staff were very welcoming when they came to visit.

The registered manager and staff had been trained in providing culturally sensitive and dignified end of life care. We saw that care plans had a dedicated section to complete when a person was at the end of their life. This provided the person's preferences, wherever possible, and guidance for staff on respecting and maintaining the individual's privacy and dignity. The healthcare professional we spoke with told us that staff had recently supported a person at the end of their life. They said, "The staff were able to put their training into practice and help the person to experience comfort, compassion and dignity at the end of their life."

The two care plans we looked at contained evidence that people's views, preferences and decisions about how their support would be provided had been listened to and incorporated into the plan of care. Each person had a written life history detailing people who were important to them, significant life events and hobbies and interests. This gave care staff good information to understand the person and what was important to them.

Good

Is the service responsive?

Our findings

The two care plans we looked at showed that people living in the home, or their representatives had participated in their assessments of need. Wherever possible the person had signed to indicate that they agreed with the care and support to be provided by staff. A relative told us they had been involved in developing the person's care plan to make sure support was delivered according to the person's preferences. They said, "The staff know what my relative can do for themself and what they need help with." The care records made sure staff had sufficient information about people to understand their needs and know how to provide safe and appropriate person-centred support.

We saw that needs assessments and care plans had been subject to monthly reviews. Where a person's needs had changed the care records had been updated accordingly. For example, we saw evidence that guidance and advice received from healthcare professionals had been added to care plans to accurately reflect the person's current support needs. A healthcare professional we spoke with confirmed that care staff always followed their guidance and made sure the care records were accurate and up to date. A record had been kept in each person's care file detailing the healthcare appointments attended and their outcome.

The registered manager told us that care plans had recently been redesigned to reflect people's information in a more person centred way. The care plans we saw included detailed life histories and the person's interests, decisions and individual preferences for the way their care and support would be provided. This provided evidence of a person centred approach to meeting the diverse and specific needs of people who used this service.

Throughout the course of the day we saw that activities undertaken by staff, provided interest and stimulation to people living in the home. For example people joined in a singsong in the lounge after lunch and we saw staff playing cards with three people. In addition to this members of staff were observed to take time to sit down and talk with people at regular intervals throughout the day. Two of the nine satisfaction surveys recently completed by relatives contained suggestions for more group activities, so we asked the registered manager about this. She said that a review of activities had shown that the people living in the home preferred and benefited more from one to one activity time, such as stimulating conversation with staff. There were some group activities provided by visiting entertainers, but a more person centred approach had been adopted so they could respond to people's personal interests.

Suitable equipment had been provided to meet the physical and sensory needs of people living in the home, such as moving and handling equipment and specialised bathing facilities. The manager had undertaken research into the needs of people living with dementia. One outcome of her research had been to provide coloured dinner plates, as it had been found that people living with dementia found it difficult to see food clearly on white plates. This had enabled people to eat independently.

We saw a copy of the home's complaints policy and noted that the procedure for making complaints was posted in a prominent position within the home. The policy detailed the timescales for investigating and responding to complaints and gave people information on where to take their complaint if they were dissatisfied with the outcome of the investigation. There were no unresolved complaints at the time of our visit. The local authority contracts officer said they had last visited the home in 2013. No major concerns had been found and they had not received any complaints about the home since their visit.

The relative and the three people we spoke with were aware of their rights in relation to complaints. They told us they were very happy living in the home. The relative said, "If something is not right I just speak with the staff or the manager and they see to it straight away. I have never needed to make a formal complaint." One of the people we asked about complaints told us, "I have nothing to complain about at all."

We saw a file containing letters and cards, which complimented and thanked staff for the quality of care provided in the home. We also saw that nine relatives who completed satisfaction surveys rated the home as very good or good. Where comments or suggestions had been made for improvement, the registered manager had responded by making improvements to the service where appropriate. This provided evidence that feedback was encouraged by the service and that action was taken to make improvements in the best interests of people who used the service.

Good

Is the service well-led?

Our findings

The manager in charge of this home was registered with the Care Quality Commission in April 2014. She had relevant experience of managing care services and had achieved a level 4 management qualification. The manager was currently studying for a level 5 qualification in health and social care leadership.

We asked the registered manager how they actively involved care staff in the development of the service. They described how they had guided staff on analysing their practice to see what had gone well and what could be improved. She said, "I attend staff handovers and encourage discussion and problem solving to enable staff to stand back and look at what they do. This way they find their own solutions to improve the service we provide." We saw evidence in records that the registered manager monitored the quality of personal care and support by working flexible hours and through staff supervision, team meetings and unannounced out of hours visits.

Three members of staff confirmed that the registered manager encouraged them to question practice within the home. Staff described the manager as supportive, approachable and open. They said there had been numerous improvements since the manager had been in post. Some of these were new profiling beds and vanity units in each bedroom, a new sluice and dementia friendly décor in bedrooms.

We saw three staff supervisions, which had been carried out the month before our visit. These records showed that each member of staff had received constructive and motivational feedback from the manager. The three staff we spoke with confirmed that the registered manager gave them feedback on their performance and also set targets for any action they needed to take. They said they felt involved in how the home was being managed.

In conversation with the registered manager it was evident that they fully understood their responsibilities. They described their plans for the continual development of the service to ensure that the changing needs of people would continue to be met through quality care and support. They told us they received good support and approval for additional resources from their line manager, who was a director for the organisation.

The conditions of registration for this service had been met and the registered manager had notified us about significant events as required by Regulations under the Health and Social Care Act.

A robust quality assurance process was in place at this home. We saw evidence of time specific auditing of procedures and systems, such as medication administration, care planning, health and safety and the use of bed rails and pressure relieving equipment. The home's approach to quality assurance was integral by involving the staff team in the process, for example infection control audits. This gave care staff the opportunity to understand that potential risks in the home could compromise quality and to learn how to manage those risks safely. All audits undertaken in the home were sent to the director each month and outcomes were discussed with the registered manager to determine any actions needed. We saw evidence that actions taken by the manager to make improvements had been signed off by the director.