Four Seasons 2000 Limited

The Triangle

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**

Overall summary

We carried out our inspection on 20 August 2015. This was an unannounced inspection.

The Triangle is a care home providing nursing care for up to 25 people. On the day of our visit there were 22 people living at the home.

At this inspection the service did not have a registered manager in post. 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 and associated regulations about how the service is run.

The home manager had recently left and the operations manager was supporting the deputy manager in the day to day running of the home whilst a registered manager was recruited.

Summary of findings

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Appropriate referrals had been made to the supervisory body.

People were positive about living in the home and were complimentary about the deputy manager and staff team. Staff were kind and caring. We saw people laughing and enjoying interactions with staff and the atmosphere throughout the home was positive.

There were not always enough staff deployed to meet the needs of people living in the home. Staff felt supported but did not always have access to regular supervision.

Staff had not always completed training to give them the skills and knowledge to meet people's needs. This included training in the Mental Capacity Act 2005 (MCA). We have made a recommendation about MCA.

People's needs were assessed and where there were risks these were assessed and managed.

Quality assurance systems had identified issues found during the inspection and action was being taken to improve.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

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 not always safe.

There were not always enough staff to meet people's needs.

People's medicines were managed safely and they received them as prescribed.

Staff were knowledgeable about their responsibilities to identify and report any concerns relating to safeguarding.

Requires improvement

Is the service effective?
The service was not always effective.

Some staff had not received training in the Mental Capacity Act 2005 and were not aware of the principles of the act.

People enjoyed the food in the home and their dietary needs were met.

When people's needs changed, appropriate referrals were made to health professionals.

Requires improvement

Is the service caring?
The service was caring.

Staff treated people with dignity and respect. Staff were kind and caring.

People were given choices in all aspects of their care and choices were respected.

People were involved in their care and felt listened to.

Good

Is the service responsive?
The service was not always responsive.

People did not always have access to activities that interested them.

Staff did not always have access to information that enabled them to provide personalised care.

People and their relatives were confident to make complaints and felt they would be taken seriously and any issues resolved.

Requires improvement

Is the service well-led?
The service was not always well-led.

Quality assurance systems had identified areas for improvement but action plans had not always been completed.

There were effective communication systems in place.

Requires improvement

Summary of findings

People were positive about the open culture in the home and the approachability of the deputy manager.	

The Triangle

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 20 August 2015 and was unannounced. At the time of our visit there were 22 people using the service. The inspection team consisted of one inspector and one expert 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.

Prior to the inspection we looked at notifications received from the provider. A notification is information about important events which the provider is required to tell us about by law.

During our inspection we carried out a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also observed care practices throughout the day.

We spoke to ten people who used the service and five visitors. We looked at six people's care records, five staff files and other records showing how the home was managed. We spoke to the operations manager, the deputy manager, one nurse, six care staff, the activity coordinator, the chef and two housekeepers.

Requires improvement

Is the service safe?

Our findings

People told us there were not always enough staff to meet people's needs. Comments included, "There have been times when I've had to wait and I've got a bit anxious but the girls are busy and it's not their fault" and "They [care staff] do all they can but they do get very busy and sometimes you do have to wait quite a long time before you get help". One relative told us, "Sometimes there are just not enough carers and people are waiting a long time to get up or for personal care".

Care staff told us that staffing levels were not always sufficient to meet people's needs. Comments included: "We're rushed; can't give high quality standard of care"; "I want to spend more time with the residents but staffing isn't managed properly" and "Sometimes it is very difficult, we can't meet people's needs. Staffing is just not enough".

Staff told us there were seventeen people in the home who required the support of two care staff to meet their needs. The staffing levels meant people were still receiving personal care up to the lunch time. Staff told us this was not people's choice but was a result of the staffing levels.

The operations manager told us the home used a dependency assessment tool to determine the staffing levels. We compared the assessed staffing levels with the rotas and found that on several occasions the staffing levels did not meet the assessed, required staffing levels. We spoke with the operations manager who was not aware that assessed staffing levels were not being met and advised this would be rectified immediately.

These were issues were breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe. Comments included: "I've got no home of my own now, this is my home and it is very good and I feel safe here", "I am safe and well cared for" and I know I am safe here, it's a feeling you get". Relatives were confident people were safe. One relative said, "I have never felt uncomfortable leaving [relative] here. I know he needs lots of care and that he will be safely looked after".

Staff were knowledgeable about their responsibilities to identify and report any safeguarding concerns. Staff understood the different types of abuse and the signs that may indicate abuse. Staff knew who to report to within the organisation and where to find the contact details of outside agencies. Staff felt confident that any safeguarding concerns raised would be dealt with immediately.

Most of the staff we spoke with had completed safeguarding training. Training records showed there were a number of staff who had not completed safeguarding training. The operations manager told us training was being addressed.

The provider had a safeguarding policy and procedures in place. There was no record of any safeguarding concerns. The operations manager confirmed there had been no safeguarding concerns raised.

People's needs were assessed and where risks were identified risk management plans were in place. Assessments included risks associated with, pressure care, nutrition and hydration, diabetes, falls and choking. One person's care plan identified the person was at risk of pressure damage due to poor mobility. The risk assessment identified the person required pressure relieving equipment and repositioning every three to four hours when in bed. The person had the required equipment in place and records showed the person was being repositioned in line with their care plan. There was no record to show that the pressure of pressure mattresses was being checked regularly. We spoke to the operations manager and deputy manager who took immediate action to put a check in place

People told us they received their medicines on time and as they required them. One person told us, "I routinely have five tablets a day and paracetamol as and when. I get it on time, every time". Medicines were managed safely and people received their medicines as prescribed. Most medicines were administered from a monitored dosage system (MDS). Audits of all medicines were completed weekly. Where people required clinical observations prior to administration these were completed. For example, one person was prescribed a medicine that required their pulse to be taken prior to the administration of the medicine. This was recorded on the MAR for each administration.

Medicines were stored safely. Temperatures were measured and recorded daily for the medicine's refrigerator and the room where medicines were stored. Records

Requires improvement

Is the service safe?

showed temperatures were within required limits. The medicine trolley was secured in a locked room when not in use and the nurse responsible for the medicine administration held the keys.

Records relating to recruitment of staff contained relevant checks that had been completed before staff worked unsupervised in the home to ensure they were of good character. These included employment references and disclosure and barring checks (DBS). DBS checks enable employers to make safer recruitment decisions and prevent unsuitable people from working with vulnerable people.

Requires improvement

Is the service effective?

Our findings

People were not always supported by staff with the skills and knowledge to meet their needs. Training records showed that staff had not completed training in line with the providers training plan. Outstanding training included; Mental Capacity Act, Deprivation of Liberty Safeguards, dementia care, moving and handling and safeguarding. Staff told us it was difficult to find the time to do the training as they were always busy with people.

One member of care staff we spoke with had worked at the home for three months. The care worker had only received training in manual handling. They explained they had shadowed more experienced staff for two weeks but had received no formal training. They told us training was 'on-line' and should be completed at work. However, the care worker had not been allocated any time to complete the training. The care worker's staff file contained no record of induction.

Staff we spoke with told us they received supervision. However three of the staff files we looked at contained no record of staff supervisions. The supervision matrix showed that staff supervisions were not up to date. Staff files did not contain annual appraisals or any records identifying staff had access to development opportunities.

These issues were breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff felt supported by the nursing team and the deputy manager. Staff spoke positively about the deputy manager. Comments included: "[Deputy manager] is brilliant. Sorts out problems really quickly"; "[Deputy manager] is brilliant, can always go to her for help" and "[Deputy manager] is very good. Will always listen and help me sort things out ".

Staff knew how to support people who present with behaviour that may be seen as challenging. Staff understood the triggers to people's behaviour and how to support them. One relative told us, "[Relative] has a very complex condition. His behaviour can change quickly and he can become slightly aggressive. Staff know how to treat him and calm him down". Staff were able to describe the person's behaviour and the steps they would take to calm the situation.

Care staff we spoke with had not received training in the Mental Capacity Act 2005 (MCA) and associated codes of practice. The MCA is a framework to ensure, where people lack the capacity to make decisions, any decisions made on the person's behalf are made in their best Interest. Staff training records showed that not all staff had received training in MCA. However, staff were able to explain how they would support people living with dementia to make decisions about their care. Staff were aware of the action they would take if a person was not able to consent to support required to meet their needs. Staff told us they would refer concerns to a nurse or the deputy manager. One staff member said, "It's important to speak to people and ask them what they want".

People's care plans contained information that followed the principles of the MCA and associated codes of practice. For example, one person lacked capacity in relation to a decision to use bed rails. The care plan contained a capacity assessment and records of discussions with family members and health professionals to ensure the decision had been made in the person's best interest. The provider was aware of their responsibilities under the Deprivation of Liberty Safeguards and appropriate referrals had been made.

People were complimentary about the food. Comments included: "I really enjoy the meals here. Good choice and plenty of food"; "I have no worries about the food here. If you want anything different then the chef will get it for you. The food is hot and tasty" and "We have a top notch chef here. The other day I had a visitor and [chef] had made the most fantastic Victoria sponge".

People were able to choose where they wanted to eat their meals. People who remained in their rooms were supported in line with their care plan.

There was a calm, pleasant atmosphere in the dining room. People were asked where they would like to sit and were supported to their seats. Staff spoke quietly with people and supported them to eat their meals in a respectful manner. Food presented looked appetising and was served from a hot trolley.

People's care plans contained details of individual dietary requirements and these were provided. For example, one person required a pureed diet. The person received a pureed meal at lunchtime and staff we spoke with knew the person required a pureed diet and the reason why.

Requires improvement

Is the service effective?

Another person required thickened fluids. The required consistency was documented in their care plan and staff knew the quantities to use to ensure the person received the required consistency.

People who were at risk of weight loss had their food and fluid intake monitored. There was good communication between nursing and care staff to ensure people's intake had been recorded where this was required. The food and fluid charts were monitored by the nurse in charge to check people achieved their recommended intake. One person's care plan identified the person was at risk of weight loss. The person was receiving a fortified diet. The care plan showed the person had gained weight.

People had access to a range of health and social care professionals when needed. Professionals involved in people's care included: Speech and Language Therapy (SALT); chiropodist; mental health team, care home support service, tissue viability and hospice services. One person told us, "I have a real problem with my eye. It is very painful. The nurse made me an appointment with the eye clinic, it was cancelled and the nurse is sorting things out". Where recommendations were made, these were detailed in the person's care plan and staff were aware of the support the person needed. For example, one person required splints on one of their arms. We saw this was in place and staff knew how to apply the splints and why they were needed.

We recommend the service seeks support and training about the Mental Capacity Act for all staff.

Good

Is the service caring?

Our findings

People were complimentary about the staff. Comments included: “They look after me well and treat me like gold dust”; “They take very good care of me. I like it here. People [staff] are very good to me and look after me well” and “[Staff member] is wonderful, when I came here I was scared of falling. She has given me confidence. I can live again”.

Relatives were positive about the care people received. One relative said, “Everyone speaks to [relative], better than being at home, he gets stimulation here”.

There was a caring culture in the home and staff spoke with kindness and compassion when speaking about people. One member of staff said, “We are like a family. It is a small home, like a family home”.

We saw many examples of caring, respectful interactions. For example, one person who was visually impaired was supported into a communal area of the home. The care worker spoke to the person, explaining where they were and what was happening. The care worker guided the person to sit down and introduced her to the person sat next to her. The care worker stayed close by until they were sure the person was settled and happy.

There was a positive atmosphere throughout the day. People and staff chatted and joked together and we heard a lot of laughter.

People were treated with dignity and respect. People were encouraged to remain independent and develop and regain skills. For example, one person had been supported to walk again. The person said, “I have been able to take one step, now I am aiming for two. The team here have given me such good care and support”.

Staff had a clear understanding of how to treat people with dignity and gave many examples of how they achieved this. For example, covering people when providing personal care, closing doors, talking to people and explaining what was happening.

People were given choices whenever they needed support and their choices were respected. One person told us, “I can do more or less what I like. Get up when you would like to. I like to get up at 11:30am because I can only sit for two hours, so I sit out and then they take me back to bed. This suits me and they respect my choice”.

People told us they knew about their care plans and were involved in developing their care plans if they wished to be. One person told us, “I have one to one consultation about my care: between the nurse and myself”. One person did not want to be involved and told us, “I don’t really bother with reviewing my care plan but I tell them what I want and they listen”.

Requires improvement

Is the service responsive?

Our findings

People were positive about living at The Triangle. One person said, "This has become my home and I treat it as my home". People could spend their day as they chose and could join in activities if this was what they wanted. One person told us they preferred to spend the day in their room and did not want to join in any activities. The person said, "That is my choice and they respect it".

People did not always have access to activities that interested them. People in communal areas spent significant amounts of time with no social interaction. The home had recently employed an activity co-ordinator, however during our visit the activity co-ordinator spent much of the time supporting people in communal areas with drinks and helping staff during mealtimes. This meant the activity co-ordinator did not have time to deliver a full programme of activities.

People told us they had been on outings. People had enjoyed a shopping trip and a day out at a garden centre. People were not aware if any further outings were planned. There were no planned activities displayed in the home.

We spoke to the operations manager about the availability of activities to interest people. The operations manager told us there were development opportunities available for the activity coordinator and these would be arranged to ensure activities were planned and took place.

People were assessed before moving into the home. People and their relatives were involved in assessments and developing care plans. People told us they knew about their care and that all aspects of their care were explained to them.

Assessments were used to develop care plans that reflected people's needs. Care plans detailed how people wished to be supported and how care needs would be met. For example one person's care plan contained an assessment following the person declining a pressure mattress, the care plan identified how the person would be supported to minimise the risk of pressure damage.

Care plans did not always contain information that was personalised. Care plans contained a 'My Choices' document, these were not always completed. This meant information was not always available to enable staff to provide individualised support.

People and their relatives were aware of the organisations complaints policy and felt confident to raise any concerns. People felt complaints would be taken seriously and responded to in a timely manner. One person told us, "I have never complained but I have made suggestions which have been responded to".

The complaints procedure was displayed in the home and gave details of who to contact. We saw that some complaints had been recorded, but there was not always a record of them being responded to in line with the organisations policy. We spoke to the operations manager who told us they were reviewing all of the complaints as they had been made aware that policies and procedures had not always been followed.

The provider had introduced an electronic feedback system which was positioned in the main entrance of the home. This enabled visitors to the home to complete feedback. This system was to replace previous annual questionnaires and had recently been introduced. One relative had completed the questionnaire and had raised an issue about a person's care. We saw the issue had been resolved.

People and their relatives were invited to meetings every two months to share information about the home and to seek feedback from people. One meeting had identified the need for review meetings to be planned and we saw these were taking place.

Requires improvement

Is the service well-led?

Our findings

People and their relatives were complimentary about the service. People told us there was an open culture and that they felt listened to. People spoke highly of the deputy manager and found her very approachable.

There was no registered manager in post. The home manager had recently left and the operations manager was supporting the deputy manager in the day to day running of the home. There was a positive atmosphere in the home and staff were committed to providing quality care to people using the service.

The organisations quality assurance systems were effective and monthly audits carried out by the operations manager had identified issues found during our inspection. For example, the operations manager had identified that the 'My Choices' documents were not being completed and pressure mattresses were not being checked regularly. The operations manager had also identified the activity co-ordinator needed additional support and development. An action plan was developed following the audits and had been shared with the then home manager. However not all actions had been completed to improve the service. The operations manager was aware of the areas requiring improvement and was working with the deputy manager to achieve the improvements.

Regular audits were carried out in the home, these included medicines, infection control, care plans and accidents and incidents. However these had not been completed on the organisations electronic system to identify when actions had been completed. We spoke to the operation manager who was aware of the lack of recording and was taking steps to address the issue. We saw this had been identified through the operations manager monthly audits.

Staff felt supported by the deputy manager and enjoyed working in the home. Staff were confident to raise any concerns with the deputy manager. Staff understood the whistleblowing procedures and felt they would be listened to.

Staff were positive about the communication in the home. There was a handover at the beginning and end of each shift. We observed the handover at the beginning of our inspection. Staff were encouraged to ask questions if they were unsure of any information shared. Staff told us handover's were a useful way of communicating and ensured all staff on duty knew what was expected of them. There were regular staff meetings that enabled staff to identify and discuss issues.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were not always sufficient staff deployed to meet people's needs. Staff did not always receive regular supervision. Staff did not complete appropriate training to ensure they had the skills and knowledge to meet people's needs. Regulation 18 (1) (2)(a)