Star Residential Home Ltd

Star Residential Home

Inspection report

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Date of inspection visit:
28 September 2016

Date of publication:
03 November 2016

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

Star Residential Home is registered to provide accommodation, nursing, treatment, disease, disorder and injury and personal care, for up to 30 people. At the time of our inspection there were 24 older adults and adults living with dementia at the service. There were a number of communal areas, including two lounges, a dining area, and gardens for people and their visitors to use. The service is situated over two floors. There are accessible bedrooms on both floors by either the stairs or a lift. There were communal toileting and wash facilities for people who used the service.

A previous inspection took place on 17 February 2015 and the service was rated overall as 'good'. There were no breaches of the Health and Social Act 2008 (regulated Activities) Regulations 2014.

This unannounced inspection took place on 28 September 2016.

There was a registered manager in place during 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.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and report on what we find. Applications had been made to the local authorising agencies to lawfully restrict people's liberty where appropriate. Staff were able to demonstrate an understanding of the MCA and DoLS to reduce the risk that people would not have their freedom restricted in an unlawful manner.

Plans were in place to minimise people's identified risks and to assist people to live as independent and safe a life as possible. We found detailed records were in place as guidance for staff to monitor people's assessed risks and health conditions.

People were supported by staff in a respectful and kind way. We saw that there were lots of positive interactions between staff and the people they supported. However, there were also some missed opportunities for staff to fully engage with the people they were assisting.

Arrangements were in place to support people with their prescribed medicines. People's medicines were stored and disposed of appropriately. However, accurate records to document people's medicines were not always kept.

When required, people were referred to and assisted to access a range of external healthcare professionals. People were supported to maintain their health and well-being.

People's support and care plans gave detailed and individual prompts and guidance to staff on any

assistance a person may require. They included the person's wishes on how they were to be supported and their likes and dislikes. An activities co-ordinator and staff assisted people with their interests and activities and promoted social inclusion. People's family and friends were encouraged to visit the home and staff made them very welcome.

Staff were trained to provide care and support which met people's individual needs. The quality of staff members' work performance was reviewed during supervisions and appraisals. This was to make sure that staff were deemed confident and competent by the registered manager to deliver people's support and care needs.

Staff understood their responsibility to report any suspicions of harm or poor care practice.

There were pre-employment safety checks in place to make sure that all new staff were deemed suitable to work with the people they supported. There was a sufficient number of staff to provide people with safe assistance and care.

The registered manager sought feedback from people and their relatives. People who used the service and their relatives were able to raise any concerns or suggestions that they had with the registered manager and staff and feel listened to.

Staff meetings took place and staff were encouraged by the registered manager to raise any suggestions for improvement or concerns that they may have had. Quality monitoring processes to identify any areas of improvement required within the service were in place and formally documented any action required and taken.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People's prescribed medicines were stored and disposed of safely.

Staff were aware of their responsibility to report any suspicions of poor care practice or harm. People's care and support needs were met by a sufficient number of staff.

Records were in place for staff to monitor people's assessed risks.

Safety checks were in place to ensure that new staff were deemed suitable to look after the people they assisted.

Is the service effective?

Good

The service was effective.

Staff were aware of the key requirements of the MCA and DoLS to make sure that people were not having their freedom restricted in an unlawful manner.

Staff were trained to meet people's needs.

Supervisions and appraisals of staff were carried out to make sure that staff provided effective care and support to people.

People's health needs were met.

Is the service caring?

Good

The service was caring.

Staff were caring and patient to the people they supported.

Staff respected people's dignity and privacy.

People were assisted by staff to maintain their independence. Staff encouraged people to make their own choices about things that were important to them.

Is the service responsive?

Good

The service was responsive.

Staff encouraged people to take part in activities and supported people to maintain their links with the local community.

There was a system in place to receive and manage people's compliments or complaints.

Is the service well-led?

Good

The service was well-led.

There was a registered manager in place.

There was an effective quality assurance system in place to make sure that when needed improvements were actioned or on-going.

People and their relatives were able to feedback on the quality of the service provided. Communication was good.

Star Residential 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 28 September 2016, and was unannounced. The inspection was completed by one inspector, a specialist advisor and an expert-by-experience. An expert-by-experience is a person who has personal experience of working with or caring for someone who uses this type of care service. The specialist advisor has worked as a nurse, health visitor, interim manager and contract manager, with specialisms in quality, older people, people living with dementia and palliative care.

Before the inspection we looked at information that we held about the service including information held and received and notifications. Notifications are information on important events that happen in the service that the provider is required to notify us about by law.

We received feedback about the quality of the service provided from a representative of the contracts monitoring team, and the interim safeguarding team manager from the local authority. We used this information as part of our inspection planning.

We spoke with five people who lived in the service, and three relatives of people who used the service. We also spoke with the owner/director, operations manager, registered manager, two nurses, a student nurse, the chef, and, three care workers. We also spoke with a visiting doctor. Throughout this inspection we observed how the staff interacted with people who lived in the service who had limited communication skills.

We looked at five people's care records, the systems for monitoring staff training and three staff files. We looked at other documentation such as quality monitoring, service users and relatives' surveys, and accidents and incidents. We saw records of compliments and complaints, the business contingency plan and medication administration records.

Good

Is the service safe?

Our findings

At the time of our inspection we saw that there were some handwritten medicine administration records (MARs) in place, which were not always an accurate record of people's prescribed medicines. We saw that for one person their MARs chart had not been accurately transcribed (copied) from the previous month. The person's dosages and frequency of medication administration that had been recorded was unclear. We also noted that other information about the person such as any allergies they had or the details of their doctor had been omitted. The provider conducted an immediate investigation into the matter and after the inspection have been able to assure us that this was a recording error and that the person had received their medicine accurately. The registered manager also provided us with documented evidence of the actions taken with immediate effect to reduce the risk of reoccurrence.

Arrangements were in place to ensure medicines were stored safely and securely and medicine trolleys were locked. Our observations during this inspection showed that people were supported by staff to take their prescribed medicines in an unhurried and patient manner. People who used the service and their relatives, who expressed an opinion, told us that they were happy with the management of their/their family member's medicines. One person said, "They [staff] bring the medication to me and it is fine." We saw that medicines were stored at the appropriate temperature and disposed of safely. We were told that it was only the nursing staff that administered people's medicines and that they had received training to do this. Records we looked at confirmed this. We saw that there were clear instructions on pharmacy printed MARs charts for staff in respect of how and when people's medicines were to be administered safely. This included those to be given 'when required.'

Where people were given covert medication (medicine disguised in food or drink), we saw that this had been agreed and signed by the pharmacist in the persons 'best interest'. Medication audits had been completed monthly. Where areas for improvement had been noted, there were documented actions in place.

People had individual and detailed care plans and risk assessments undertaken for any identified risk, support and health needs. We saw that people were kept as safe as possible and the majority of risk assessments monitoring charts seen were completed.

We saw that the provider had a business contingency plan for the service in the event of a foreseeable emergency. The plan contained information to be used as a prompt for staff. People had individual personal emergency evacuation plans in place. These plans provided guidance for staff about how each person needed to be supported during an evacuation. This showed us that there were plans in place to support people to be evacuated safely in the event of such an emergency, for example a fire.

People who used the service and their relatives told us that they or their family member felt safe in the service. One relative said that they thought the service was safe because, "They [people] get the care they need." Another relative told us, "The home is safe and I can go home and sleep. I couldn't find a better place."

Staff told us that they had undertaken safeguarding training and records we looked at confirmed this. They demonstrated to us their knowledge on how to identify the different types of harm and report any suspicions of harm or poor care practice. Staff told us what actions they would take in protecting the people they assisted and reporting such incidents. One staff member said, "I would report a safeguarding concern to the nurse. You can also report concerns to the Care Quality Commission, the police and the council [social services]." This demonstrated to us that staff knew that they could also report any concerns to external agencies.

Staff spoken with said that they would have no concerns to whistle-blow if they suspected poor care practices. One staff member said, "[Staff] have a duty of care, I would be confident to whistle-blow if concerns were around [poor] care."

Records showed, and staff confirmed to us, that that pre-employment safety checks were carried out prior to them starting work at the home and providing care. One staff member said, "I have worked here for [number of years], my DBS [disclosure and barring service criminal records check] was last checked this year, it's checked every two years." Checks included references from previous employment, a criminal record check that had been undertaken with the Disclosure and Barring Service, proof of current address and photographic identification. Any gaps in employment history had been explained. These checks were carried out to make sure that staff were deemed suitable to work with people living in the service.

Our observations showed that during this inspection there were sufficient staff on duty to meet people's assessed needs. We saw staff in communal areas of the service supporting people and on the corridors, and staff were available so that people could ask for information when needed. Staff were busy, but they did not rush people, and assisted people at their own preferred pace. One relative said, "There are enough staff on all the time." Another relative told us, "There are plenty of staff on." One person said, "There are enough staff on, so I get everything I need." A nurse told us, "Staffing levels are good. If we are short staffed everyone [staff] is phoned and failing that we will call our sister [providers other] home."

We saw that people had their dependency levels assessed to check whether they needed support from either one or two staff members. The registered manager explained how this information established the staffing levels that met people's care and support needs within the service. This indicated to us that there was a process in place to ascertain the number of staff needed to meet people's needs.

Good

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 applications for this in care homes 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.

During this inspection we spoke with the registered manager and a nurse about the MCA and changes to guidance in the Deprivation of Liberty Safeguards (DoLS). We found that they were aware that they needed to safeguard the rights of people who were assessed as being unable to make their own choices and decisions. Applications had been made for people, who required this safeguard, to the local authority supervisory body.

Staff and records showed that staff had training on the MCA. On speaking with staff we noted that they had knowledge about the MCA and understood this in relation to the service they provided. One staff member said, "The MCA key principles are that it protects people who can't make a decision for themselves, we [staff] then guide them…and make decisions in people's best interest. People who have dementia can make decisions, [you] guide them and give them choices such a visual prompts." This understanding reduced the risk that any decisions made on people's behalf by staff would not be in their best interest and as least restrictive as possible.

Relatives told us that they were happy with the food served to their family member in the service. The food was said to, "Be good," by one relative. They went on to explain how the chef purees their family members food due to their deteriorating health condition and being at risk of poor swallowing/ choking. The majority of staff we spoke with had an understanding of the different diets people's health conditions may need. For example; food softened in line with speech and language therapists (SALT) guidelines for people at risk of poor swallowing or low sugar diets. However, one new staff member was not able to tell us what SALT guidance meant. We spoke with the registered manager about this during the inspection and they confirmed to us that the member of staff would receive further training.

We saw that people were provided with a selection of hot and cold drinks and snacks throughout the day. Our observations during the meal time showed that people could choose where they wanted to eat their meals. Some people chose to eat in their own rooms, in the lounge or at the dining room tables and this choice was respected by staff. We saw that where people needed some assistance from staff with their meals this was carried out in a patient manner at the persons preferred pace. People were offered other choices of food by staff if they were unhappy with the main choice. This showed us that staff supported

people to maintain their own independence and choices. However, we did see that one person who used a frame for their mobility, was sat in their room with their frame and a drink out of reach. We spoke to the registered manager about this during the inspection and they told us that they would make sure staff were aware of the need to keep people hydrated.

Staff had an induction period which included mandatory training and the shadowing of a more experienced member of staff and attending supervisions. We saw evidence that the provider had adopted the Care Certificate induction training programme. This is a nationally recognised training scheme. All new staff had to complete an induction period until they were deemed competent and confident by the registered manager to deliver effective care and support to people in the service.

Staff members told us they enjoyed their work and felt supported. Staff said they attended staff meetings and received formal supervision and appraisals of their work. One staff member said that these were, "Two way conversations." Another staff member confirmed to us that they were, "Up to date with their supervisions." This meant that staff were able to use this time set aside by the registered manager, to discuss anything that they wished to. This showed us that staff were supported within their job roles.

Staff told us about the training they had completed to make sure that they had the skills to provide the individual care and support people required. This was confirmed by the record of staff training undertaken to date. A staff member said, "I have recently undertaken end of life training." Another staff member told us, "I have had training from the staff nurse yesterday on oxygen therapy and have done some dementia training."

Records showed us that training included, but was not limited to; basic first aid; infection control; MCA and DoLS; dementia awareness; safeguarding and health and safety. We also saw training undertaken on, diversity and equality; challenging behaviour; food safety; medication; fire awareness and moving and handling safely. This showed us that us that staff were supported to develop and maintain their knowledge and skills.

Records showed that staff involved and referred external healthcare professionals if there were any concerns about the health of people living at the home. We saw documented evidence of visits from the doctor and dietician involvement. A visiting doctor told us that they visited weekly and had never seen anything at the service that would cause them concern. This showed us that staff referred people to external healthcare professionals when needed.

Good

Is the service caring?

Our findings

People who used the service and their relatives told us that staff were kind and polite. The majority of our observations showed evidence of kind and patient interactions by staff. One relative said that, "The staff are very good…[family member] is always clean and dressed. They [staff] call us to ask if they can cut [family members] nails or hair. They always ask before they do anything." One person told us, "I like living here; they [staff] are very nice." Another person said, "From what I see [staff] are very nice." We saw some staff members crouching down to make eye contact with the person they were supporting or take the persons hand as reassurance. These gestures were done by staff to try to reduce the person's anxiety or to show respect. We also saw staff reassure people with a kind word or gesture. We heard how the majority of staff spoke with people in the home, which was respectful, patient, and caring.

However, we observed some missed opportunities for staff to engage with the people they supported. We noted that some staff did not always speak to the person they were assisting. For example, we saw occasions when staff were supporting a person with their lunchtime meal with little or no interaction. This meant there were some missed opportunities from some staff working at the service, to make the mealtime experience a meaningful and enjoyable social experience for people. This included a person who was supported to the dining table for lunch at 11.50am and was sat waiting until 12.30pm when lunch was served. They were heard saying repeatedly, "I don't know when we will get lunch?" After 20 minutes the activities co-ordinator sat with the person and played a game as a successful distraction until lunch was served. We spoke with the registered manager about the missed opportunities by some staff and they told us that they would look into this and make the necessary improvements.

Our observations showed that during this inspection people's dignity was respected. We noted that people were supported by staff, where needed, to be appropriately and cleanly dressed. We saw and heard how staff knocked before they entered a person's bedroom. We also saw staff readjusting people's clothing to make sure that their dignity was not compromised.

Care records had been written in a way that promoted people's privacy, dignity and independence. Staff had endeavoured and succeeded in collecting personal information about people living at the service. This also included their individual likes and dislikes, any preferences they had, and their individual support and care needs. Care plan reviews took place to make sure that people's care and support plans were up-to-date and met people's current needs. One relative said, "My [another family member] went to a review last week, everything was good. They [staff] told us what is happening and updated us with changes. The next one [review] is booked in for December."

Where people had 'end of life' plans in place this had been documented as guidance for staff. One relative wrote to the service, "We couldn't have asked for more caring and dignified last hours for [family member]." We saw that where 'do not resuscitate' directives had been completed all necessary information had been completed and was correct. For example the address of the home, reason for the decision and signatures from all parties involved. This meant that people were supported with their end of life wishes.

People's friends and family were encouraged to visit the home at any time and made to feel very welcome by the registered manager and staff. One relative told us how staff had arranged for the family to use one of the lounges to celebrate their relative's birthday. This was done to give the family, "Space together [with their relative] away from everyone else." Another relative said, "I am allowed to come when we want. There are no restrictions."

Advocacy information was made available to people who required this support. We saw documented evidence of where an advocate was used during a person's 'best interests' assessment. Advocates are for people who require additional support in making certain decisions about their care.

Good

Is the service responsive?

Our findings

There was a pictorial activities board in the communal dining room which detailed what activities were to take place each day. On the day of our inspection we saw the activities co-ordinator engaging and encouraging people to take part in making jam tarts. The activities co-ordinator encouraged people in the communal lounge and dining area to take part in various stages of the bake. They took the pastry round to each person and supported them to cut out pastry shapes and then to fill the tarts with various fillings. Where a person requested a particular filling this was done by the staff member straight away. We saw that this activity encouraged people to share their baking tips and tricks with others and those taking part were seen to enjoy this activity.

There are two gardens at the service and we observed people independently using the garden when they wished to do so. Later on we saw people taking part in a ball game, whilst others listened to music, completed a word search, knitted or read magazines. One relative told us, "[Family member] gets care 24/7 which we can't do."

Support and care plans were developed by staff in conjunction with the person, and/or their family. These provided prompts to staff on the care and support the person needed and their wishes. This was then used as information and guidance for the staff that supported them. The individual support that people received from staff depended on their assessed needs. Support included assistance with their prescribed medicines, personal care and meal time support. Reviews were carried out to ensure that people's care and support requirements were recorded, updated and met the persons current care needs. One relative said, "[Family members] condition has got progressively worse and the home [staff] have changed [support and care] as they have needed to." They went on to tell us that they were happy with how staff had responded to their family members changing needs.

For those people in the service who did not speak English as their first language we found that several staff spoke two or more languages. As a result staff were able to support people in their native tongue were able to understand and respond to people's needs and wishes.

Records showed that the provider had received compliments about the quality of the care provided. One relative wrote, "Thank you so much for all the care that you gave [family member]." Another relative wrote, "You have a fabulous place here with wonderful staff – thank you for taking care of [family member]."

People who used the service and their relatives told us that they felt listened to by the registered manager and/or staff if they raised a suggestion or complaint. One relative told us, "I have not seen anything that concerns me but I would raise it immediately…I would be happy to raise [a concern] with the [registered] manager." Another relative gave an example of a concern that they had raised with the registered manager and that it had been listened to and resolved to their satisfaction. Staff demonstrated to us that they knew the process for reporting concerns or complaints. One staff member said, "I would ask permission [from the person] to raise the complaint with the nurse or [registered] manager." Staff also told us how learning from complaints or concerns raised was shared with other staff during 'hand overs,' to reduce the risk of re

occurrence. Records showed that complaints received had been responded to in a timely manner and resolved where possible.

Good

Is the service well-led?

Our findings

There was a registered manager in place. The registered manager was supported by care staff and non-care staff. Staff told us that an open and honest culture existed and they were free to make suggestions and raise concerns to drive improvement. One nurse said, "The registered manager is hands on, supportive and visible [throughout the service]." Another member of staff told us, "I feel supported. I can speak to [registered manager] any time I want about any problems or concerns."

People who used the service and their relatives told us that they knew who to speak with, and that the registered manager was approachable. One relative said, "I have no concerns, I have not seen anything that concerns me. Up to now it is all brilliant."

People and their relatives were given the opportunity to feedback on the quality of the service provided. The questionnaire was in an 'easy read' format to make it more accessible to people living in the service. We saw that there was a high level of satisfaction, and information from the feedback was used to improve the quality of service where possible. One area highlighted for improvement was that staff were to continue to build up the confidence of the person that they were supporting.

Feedback was also requested by the registered manager from staff who worked at the home to see if they felt supported and if they could suggest any improvements. Responses from staff who completed this survey were positive. Visiting Health and social care professionals who were involved with the service were also asked to give their views. Feedback from this survey showed that positive comments were received about the quality of service provided for people living at the service with no improvements required. One professional wrote, "Staff are always friendly, polite and chatty.' Another wrote, "Great staff and great care provided."

We saw that some staff had 'lead roles' within the home. These roles included a champion for dementia care, wound care, end of life, and infection control. Staff told us that these roles were in place to maintain a high standard of care and be a point of guidance for other staff.

The registered manager notified the CQC of incidents that occurred within the home that they were legally obliged to inform us about. They had always done this in a timely manner. This showed us that the registered manager had an understanding of the registered manager's role and responsibilities.

The registered manager showed us records of their on-going quality monitoring process. Monitoring included, but was not limited to; a monthly manager's audit; dignity in care; care documentation; fire safety; infection control, and medication. There was also a medicines audit undertaken by one of the assigned pharmacies to the service. Results of these audits showed that where improvement actions were needed, these were taken.

The registered manager also had to complete an organisation 'trends analysis report'. This monitoring looked at many areas of the service including, accidents and incident figures; falls records; people's

nutritional status; people's pressure sore analysis; internal audits undertaken and their findings. This information was used to look at the quality of the overall service provided and any 'trends' [patterns] in the data. Any trends found were then used to highlight areas requiring improvement. This demonstrated to us that the registered manager had systems in place to monitor the quality of the service provided at the home, make improvements and sustain these.