Marcus Care Homes Limited

Enstone House

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

Summary of findings

Overall summary

We inspected Enstone House on 15 June 2016. Enstone House provides personal care for people over the age of 65, with a diagnosis of dementia. The home offers a service for up to 36 people. At the time of our visit 36 people were using the service.

There was a registered manager in post at the service. 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.

At our last inspection on 12 May 2015 we found that not all relevant checks had been completed for one individual before they worked unsupervised and there was no risk assessment for this staff member in place. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found the registered manager had no system in place to audit incidents which would enable them to identify trends or concerns across the service. We also identified there was no evidence of the actions which had been taken following the satisfaction survey. Additionally there were no audits of medicines, care plans or other measures of how the registered manager or provider monitored the quality of the care people received. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found the provider had addressed the above concerns. We saw the risk assessments for staff had been put in place where required. The registered manager ensured the safe recruitment practices were followed. We noted accident and incident recording procedures were in place and appropriate action had been taken where necessary. A number of audits was introduced and carried out regularly. This included care plan audits, medication audits, monthly house audit and a cleaning audit. We noted a responsive action was taken if required. The registered manager also ensured any action arising from satisfaction surveys were followed up promptly.

People and their relatives told us they had no concerns about people's safety at the home. There were safeguarding procedures in place and staff received training on safeguarding vulnerable people. Staff had the skills and knowledge to recognise and respond to any safeguarding concerns.

Risks to people were identified and managed well. A range of detailed risk assessments were in place and identified how to manage the risk of injury or harm to people during the provision of support.

Medicines were administered in line with safe practice. Staff who assisted people with their medicines received appropriate training to enable them to do so safely. People were supported to maintain a balanced diet. People were also supported to access health care professionals when required.

We found there were sufficient staffing levels to meet people's needs effectively. The staff team worked well

together and were committed to ensure people were kept safe and their needs were met appropriately.

There was an on-going training programme to ensure staff had the skills required to carry out their roles. Staff received appropriate support through induction and supervision. Staff told us they felt able to speak with the management team or senior staff at any time.

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. Staff and the registered manager understood the MCA and DoLS and the provider followed the legal requirements.

People were cared for by caring and compassionate staff that knew them well. The staff treated people with dignity and respect. People were encouraged to be involved in decisions about their care. There were a range of activities on offer for people to participate if they chose to do so.

People had care plans in place that documented their needs and preferences for how they wished to be supported. These were reviewed and took into account any changes in people's needs over time. The provider had a system in place that ensured they listened and learned from people's feedback and complaints. People and their relatives told us they knew how to complain and felt their concerns were addressed promptly.

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 individual risks were assessed and management plans were in place how to manage these.

Staff were aware how to keep people safe from suspected abuse and how to recognise any safeguarding concerns.

There were enough staff to meet people's needs.

People received their medicines as prescribed.

Is the service effective?

Good

The service was effective.

Staff received regular supervision and training.

People were encouraged to make decisions about their care. Decisions made on behalf of people who lacked capacity were made in their best interests.

People received the healthcare support they needed to maintain their health and well-being.

People's nutritional and dietary needs were met.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect.

People were supported by staff that engaged positively with them whilst the care and support was provided.

Staff knew people well and understood people's needs and how they liked to be supported.

Is the service responsive?

Good

The service was responsive.

People had detailed care plans which helped staff to provide care in the way it met people's needs.

The service responded appropriately when people's needs changed.

People had opportunities to take part in activities and social events in order to maintain social stimulation.

People and their relatives were able to discuss concerns and these were appropriately addressed.

Is the service well-led?

Good

The service was well-led.

The registered manager and staff worked well together as a team.

People, staff and relatives were able to talk with the registered manager when they needed information or support.

The registered manager ensured quality assurance systems were in place to monitor the quality of care provided and drive improvements within the service.

Enstone House

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 and to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 15 June 2016 and was unannounced. The inspection team consisted of one inspector, a Specialist Advisor in elderly care and an 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.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). The provider had completed and submitted their 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 also looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. This enabled us to ensure we were addressing potential areas of concern. We also spoke with the local authority safeguarding and commissioning teams to seek their feedback about the service. We also contacted five external professionals to obtain their views.

During the inspection we spoke with nine people who were living at Enstone House and two people's relatives. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We also spoke with two care staff, two senior care staff, the chef and the registered manager. We looked at six people's care records and at a range of records about how the service was managed. We also reviewed staff files for three individuals, including their recruitment, supervision, training records and the training matrix for all the staff employed by the service. After the inspection we contacted three relatives to obtain further feedback.

Good

Is the service safe?

Our findings

At our last inspection in May 2015 we found that not all relevant checks had been completed to ensure staff were suitable to work with vulnerable people. The Disclosure and Barring Service check had not been received for one staff member and they had been allowed to work unsupervised. DBS are checks that help employers make safe recruitment decisions and prevent unsuitable people from working with vulnerable people. The registered manager had asked people and their relatives if they were happy for the member of staff to work in the home. However, the registered manager had not followed guidance fully to risk assess the member of staff who was working unsupervised without the necessary checks. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found the provider had addressed these concerns. We saw the risk assessment had been put in place. The registered manager ensured that safe recruitment practices were followed. The records viewed confirmed appropriate checks were undertaken to ensure staff were of good character and were suitable for their roles. Staff files included application forms, records of identification and evidence that checks had been made with the DBS to make sure staff were suitable to work with vulnerable people.

People told us that they felt safe at the service. One person said: "I feel quite safe here". The relatives we spoke with said that they had no concerns about the safety of their family members. A relative said, "I do feel that [person] is safe here".

Staff received training around safeguarding vulnerable adults. We spoke to a member of staff and they were aware how to recognise signs of abuse. They told us, "I would document findings on the body map, report issues to the family if appropriate, seek medical assistance in an emergency and inform the manager". The registered manager and the staff were aware of the local authority reporting process in relation to safeguarding concerns. They understood their responsibilities in promptly reporting concerns and taking action to keep people safe.

There were sufficient staff to meet people's care needs. People told us they felt there was enough staff. One person said, "I'd think we have enough staff, you don't need to wait long for staff to help me". Staff also told us there were enough staff on duty. One member of staff said, "Yes, we have enough (staff), we're not rushed".

We observed the administration of medicines and we saw that medicine was given to people safely. The staff wore a 'do not disturb' tabard to alert staff that they should not be disturbed and to reduce the risk of medication error. People received medicines as prescribed and medication was kept securely. The amount of medication, including Controlled Drugs in stock corresponded correctly to stock levels documented on Medicines Administration Records (MAR). The MAR is a document showing the medicines a person has been prescribed and records when they have been administered. There were no missing signatures on the MAR. The provider had a medicines policy that included the principles of safe administration, handling of medication, homely remedies and covert medicines. This policy underpinned national good practice guidance.

People were protected from risk as risk management plans were in place which detailed the support people required to manage the risk and keep them safe. For example, one person was at risk of developing pressure areas. They had a skin integrity risk assessment and we noted the person was cared for on a pressure relieving mattress. The person also had a risk assessment for falls and moving and handling transfers. The risk assessments were detailed and provided guidance to the staff. For example, one person's bathing and showering risk assessment stated "one member of staff to assist at all times during [person's] personal care, not to be left alone in the bathroom". People's risk assessments were reviewed monthly or as and when required.

People's safety in relation to the environment was assessed and managed appropriately. We saw checks were undertaken on the environment to ensure it was safe for people. For example, water temperatures, water safety tests and fire alarm system checks.

Good

Is the service effective?

Our findings

People and their relatives spoke positively about staff and told us they were skilled to meet their needs. One person said, "I think they are well trained". One relative told us, "They (staff) seem to know what [person] has been up to".

People were cared for by knowledgeable staff that had the right skills to look after people. The training matrix demonstrated that training relevant to the care needs of people such as safeguarding, health and safety, moving and handling, person centred care and first aid had taken place. Staff also completed a Level 2 dementia certificate course. Staff told us they felt the training provided was appropriate for their roles and they could request further training if needed. One member of staff said, "We can suggest training that would be beneficial and the manager will support this". Another member of staff said, "The manager wants us to better ourselves, training is sorted out".

Staff were appropriately supported to help them effectively carry out their roles within the service. We saw records were kept of when staff had met with their line manager for supervision. Additional assessments such as observations, probationary reviews or annual appraisals were carried out to assess and monitor staff performance and development needs. Staff we spoke with confirmed they felt well supported. One member of staff said, "Yes, supervision is regular". Another member of staff said, "We can go to manager or a senior at any time".

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 in order to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). When we talked with staff about this, we found they had a good knowledge and understanding of the MCA and had received relevant training. One member of staff told us, "We assume capacity unless it's proven otherwise".

We noted the correct process was followed when people were unable to make certain decisions. For example, one person was assessed as needing to receive their medicines covertly. We noted the decision making process included rationale and the person's GP and their relative was involved. The local NHS Foundation Trust good practice guidance regarding covert medicines was included and the decision was reached in the person's best interest.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there were any restrictions to their freedom and liberty these had been authorised by the local authority as being required to protect the person from harm. The registered manager understood when an application should be made to the relevant authority and how to submit one. They informed us that three people were subject to

Deprivation of Liberty restrictions and their care records included appropriate records to support this.

People were given choices in the way they wanted to be cared for. We observed a member of staff offered to manicure a person's nails. The member of staff asked permission of the person before placing a towel over the person's laps and carrying out the task. We also observed people were given choice of drinks throughout the day and the choice of where they wanted to sit.

The staff were aware of people's dietary needs and preferences. People's nutritional needs and preferences were clearly recorded in their care plans. Where necessary, people's food and fluid intake was monitored and recorded to ensure they met their needs. Information about people's dietary preferences, food allergies or intolerances was available in the kitchen. The chef told us, "I am happy to cater for more or less anything, gluten-free and dairy free (diet)".

People complimented the food. One person told us, "The food is very good, I don't think there's been one meal I have not eaten". Another person told us, "There is a choice of breakfast, I had chosen porridge (this morning). The food is good we can't really complain". One relative said, "[Person] settled in very well, she's eating well and has gained a bit of weight since she has been here as she is eating far better than when she was at home".

We observed the lunch service and noted the meal was split in two sittings to make sure people who needed assistance were supported promptly. We saw people were assisted appropriately, were not rushed and staff allowed them time to eat before offering another mouthful. The dining experience observed was positive, tables were with a cloth serviette, cutlery and a glass of orange squash or water as per the person's choice. The staff were attentive and offered more drinks or condiments throughout the meal. The staff were observed offering to cut up food for people if they required and they talked to people the whole time they were assisting them. We saw staff engaged with people well. For example, a member of staff asked the person "What's your favourite food?" The person answered, "Mash potatoes". The member of staff was then heard saying "This is what you're having".

People were supported to meet their healthcare needs. Any changes in their health or well-being prompted a referral to a healthcare professional. One person told us, "If I ever need to see a doctor they will organise that for me". Staff reported the multidisciplinary involvement for people included the local NHS Care Home Support Service, speech and language therapists, memory clinic and dietician. GPs from the local surgery visited the service regularly.

Good

Is the service caring?

Our findings

People told us they felt the staff were caring. One person said, "The staff are very good, I don't know how they put up with us". Another person told us, "I am well looked after ". One relative told us, "I'm very impressed with the way residents are treated. They are treated with kindness, and staff address them as if they were their own family". They added the local health professional "spoke very highly of the home and the care it provided for residents". Other comments received from relatives included, "[Person] is well cared for by the staff" and "The residents seem happy and well cared for".

People were cared for by staff that understood them and knew their personal preferences. We observed people appeared content and relaxed in the company of staff. Interactions between people were positive and demonstrated a sociable atmosphere in the communal areas of the service. When people were distressed, staff were at hand to comfort them. For example, one person dropped a cup and saucer on the floor breaking the cup. We observed the staff attended immediately and said, "No problem, did you not want that cup and saucer?" before getting to clear up the broken pieces. Another member of staff was observed kneeling on the floor beside a distressed person placing her hand over her shoulders and talking to her quietly.

Throughout the inspection we saw staff treated people with dignity and respect. The staff were very attentive and engaged with people well. For example, were getting down to their level when communicating with people. People told us staff respected them. One person said, "Oh yes, they (staff) do". One relative told us, "I couldn't be happier with the way the staff have treated [person] since they've been there". Another relative told us, "[Person] is treated with dignity and respect, and there is a real bond of affection between staff and residents - they are recognised and treated as individuals". Staff gave us examples how they ensured people's dignity was respected. One staff member said, "I'd shut the door when providing personal care and I do not speak about others (people at the home)".

People were able to express their views and were involved in making decisions about their care and support. One person said, "I can choose when I get up, it is usually about 8.30 and that suits me". Another person told us, "They (staff) involve me in any decision about my support". We noted the care records reflected the importance of involving people. One person's care plan stated, 'ensure her choice is respected at all times'. Another person's care plans read '[person] is able to choose their own clothes".

People's bedrooms were personalised and decorated to their individual taste. One person's bedroom had many personal items. For example they showed us a trophy for a competition they won when they were younger. People were also encouraged to keep their own pets. One person had a cat and a parakeet. People complimented the home and the support they received.

Staff told us that people were encouraged to be as independent as possible. One member of staff said, "We're trying to get them (people) to do as much as they can, for example, they can have their breakfast in a dressing gown and then spent longer dressing themselves (rather than the staff doing this for people)". We noted people's care plans stated 'encourage and maintain independence'.

People had access to advocacy services when they needed them. Advocates are people independent of the service who help people make decisions about their care and promote their rights. The records showed that where advocacy was required they were involved.

Good

Is the service responsive?

Our findings

People's needs were assessed prior to admission to the service in order to ensure the team had sufficient information to draw care plans that met people's needs. People's choices and preferences were clearly documented in their life histories. For example, one person's file read, "My name is (person's name) but I don't like my name, I prefer to be called (alternative name)" and "'Likes listening to music and being out in the garden in good weather, likes strong coffee and orange squash. Does not like when things get too loud, likes to know staff are around and [person] isn't alone'.

Care plans were current, clear and person centred. This included care plans for call bells, continence, use of equipment including walking sticks and bath hoist, mental capacity, cognition, memory, sight, hearing and communication. They contained information about people's care needs and their conditions. For example, one person's care plan read, "'[Person] was diagnosed with dementia but has little insight into her cognitive impairment. [Person] expresses feelings of loss of control in her life and frequently needs (help with) orientation to recognise the time and place".

People received personalised care. For example, one person was assessed as having a poor appetite. The person was prescribed supplementary drinks by her GP and their care plan stated they needed to be weighed regularly and their food intake needed to be recorded. We noted the person's weight was recorded weekly and that their food intake charts were recorded appropriately.

People's relatives commented positively on how the service met their family members' needs. One relative told us, "They have altered their care regime to accommodate [person's] needs and they respond very quickly if there's a problem". Another relative told us, "I had a conversation with the manager and we talked about how they would adapt the care of [person due to the change in their mental state which allowed them more time for thought processes".

There were activities and social opportunities available to people living in the home. A staff member told us there was an activities programme but this often changed if people wanted to do something different or people showed little enthusiasm for the scheduled activity. We observed various activities on the day of our inspection. We saw seven people were sat at a table in the dining room doing craftwork, three people were playing scrabble with a member of staff and one person was doing a large piece jigsaw puzzle. Another person was observed enjoying doing some colouring with water paints.

There were enough staff so that there could be flexibility and spontaneity regarding social interactions and support. For example, one person wanted to go to the shop. This was facilitated and the person went out. We saw them later and they showed us they bought two papers and some sweets. The person appeared happy having been out doing something that would have been her normal routine prior to her taking up residence in the home. The person told us, "I often go to the shop".

People's daily activities were recorded in their care files. For example, one person's file read, '[person] enjoyed karaoke party', 'read a book and did a puzzle', 'enjoyed animal visit' or 'been out for Mother's Day

tea'.

There were procedures in place to enable people to make complaints about the service. Information was available to people and visitors. There were no formal complaints recorded. People told us they knew how to complain. One person said, "If I had any issues I'd speak to any of the staff". One relative told us, "Any concerns have been dealt with very quickly". The records showed the service received seven compliments this year.

Good

Is the service well-led?

Our findings

At our last inspection in May 2015 we found while each incident was recorded, the registered manager had no system in place to audit incidents which would enable them to identify trends or concerns across the service. We also identified there was no evidence of the actions which had been taken following the satisfaction survey. Additionally there was no evidence around audits of medicines, care plans or other measures of how the registered manager or provider monitored the quality of the care people received. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that provider had made improvements. For example, accident and incident recording procedures were in place and we noted appropriate action had been taken where necessary. The registered manager implemented a log of auditing system for accidents to identify any trends or patterns and prevent reoccurrence. The log reflected that areas such as where an accident occurred and time of the day were considered. The audit also evidenced that additional referrals such as a safeguarding alert or a Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) notification were considered and submitted if necessary.

A number of audits was introduced and carried out regularly. This included care plan audits and care reviews, medication audits, monthly house audits and cleaning audits. We noted action was taken as required. For example, we saw documentation regarding a recent pharmacy visit with actions taken in response to the areas for improvement identified.

The registered manager also ensured any action arising from satisfaction surveys were followed up promptly. For example, we noted following the recent survey it has been identified that some relatives expressed they were finding it difficult to identify staff roles. The registered manager updated the staff picture board displayed in the reception of the home in order to help the relatives to recognise the staff and their roles at Enstone House.

People and their relatives spoke positively about how the service was managed. One person said, "Very nice place". One of the external professionals told us, "My dealings with them have been very professional and they have always been willing to help where they can". One relative told us, "Someone is always available to talk, no passing the buck, staff always identify themselves which means they take ownership for things". Another relative commented, "We have good communications with the manager".

There was a clear structure of the team and staff were aware of their roles and responsibilities. The staff complimented the support they received from the registered manager and the atmosphere at the service. One staff member told us, "[Registered manager] is the greatest manager and is supportive and has helped me in my role, she does so much for the Home'. Another staff member told us, "The manager always listens, welcomes feedback and I feel empowered". Another member of staff stated "I am proud of the home, happiest I've been, I consider this my home". Staff told us the values of the service included 'safety for people' and that 'residents were loved and were part of a family'. People and relatives also made positive

comments about the registered manager and their hand on approach.

Staff told us and records confirmed there were regular staff meetings and any issues raised were addressed by the registered manager. Staff told us they contributed to the running of Enstone House. One staff member told us, "In the past there had not been time allocated for resident's reviews but the manager addressed this and time has been now allocated". This meant staff were able to spend uninterrupted, quality time with people when carrying out their reviews.

The registered manager understood their responsibilities in relation to their registration with the Care Quality Commission (CQC). They had submitted any notifications to us, in a timely manner, about any events or incidents they were required by law to tell us about. We use this information to monitor the service and ensure they responded appropriately to keep people safe.