Cedar Care Homes Limited

Saville Manor Nursing 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

Summary of findings

Overall summary

Saville Manor is registered to provide nursing care for up to 42 people with enduring physical conditions or conditions resulting in physical disability. On the days of our visit there were 31 people living at the home. The visit took place on 30 and 31 May 2017 and was unannounced. We last inspected the home on October 2014 and no concerns were found at that time.

There was no registered manager for the service as they had very recently left. There was an acting manager in post. They had worked for the provider for a number of years. They were in the process of applying to be registered with us. 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.

People were safe and CQQ and the Local Authority had been informed of most of the relevant safeguarding concerns. However one recent allegation of poor practice had been dealt with by the provider internally. Action had been taken to keep people safe but the CQC and Local Authority had not been informed of the concern. The provider sent us information after our visit to explain how they had made this decision. However the nature of the concern meant it could be considered to be a safeguarding matter.

We have made a recommendation about staff training to ensure correct safeguarding reporting procedures are followed.

Staff were being supervised by the management and other senior staff. The provider had a clear supervision procedure in place that set out how this process was aimed at developing and supporting staff. However, supervision at the home had regularly been carried out in in a way that could be seen as negative towards the staff members being supervised. This could lead to staff not feeling motivated or valued in their work.

We have made a recommendation around staff supervision so that it is carried out in a way that is beneficial to staff and people at the home.

Risks to the safety and wellbeing of people were reduced because staff had completed safeguarding adults training, and knew how to identify the different types of abuse. Risk assessments were in place that identified the areas where the safety of people may have been at risk. Accidents and incidents were reviewed and actions taken to keep people safe. Trends were also identified to reduce the risk of reoccurrences. There were safe practices and procedures for the management of medicines in the home.

People told us they liked the food and we saw they were offered choices at each mealtime to help them decide what meal they wanted. People at the home and the staff had developed caring relationships. This was also the case with relatives and friends who spoke highly of the caring attitude of the staff.

Staff had an understanding of the needs of the people they supported and knew how to care for them in a way that met their needs. The staff we saw had a caring and attentive manner towards the people they supported who lived at the home. We saw that whenever possible, people were involved in making decisions about their care and support needs. People were offered discrete and sensitive assistance if they needed support to eat their meals or with intimate care.

When people had specific health needs and concerns there were arrangements in place for them to see their GP and other healthcare professionals. Staff closely monitored the health and well-being of people on an on-going basis. People were supported to consume the food and drinks they enjoyed and they were able to choose what they wanted. People were given discrete assistance if they needed support to eat their meals. The staff knew how to support people effectively and in a way that fully met their needs. The team of staff at the home were caring and supportive in manner towards each person they supported.

People had their needs met by a team of properly trained staff. The staff attended frequent training opportunities and were developed in their work. This helped them to improve and develop their skills and competencies. Nurses were supported to go on regular clinical training and updating of their skills. This was to help them to be able to provide nursing care based on best practices.

There was a safe level of suitably qualified staff on duty at any time .The provider had devised their own dependency tool to calculate the numbers of staff required. The tool also helped work out the skill mix of staff that were needed to provide safe care at any time. The numbers of staff had been identified based on how much support and care each person required.

People received care and support that met their individual needs. People were encouraged whenever possible to make their own choices and decisions in relation to their daily life. When people did not have full capacity to make decisions staff understood what to do to ensure that decisions made on behalf of the person were in their best interests. We found the service to be meeting the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People were able to take part in a wide variety of lively and informal one to one and group activities. The environment was personalised with features that were beneficial for people who lived there. There was a secure garden and comfortable seating areas. There was also a variety of decorative items to make the place more homely.

People and those who represented them were supported to be able to complain and make their views known. The provider actively sought the views of people and their families. Suggestions were acted upon and changes were made to the service when needed. Feedback about the home from people and others involved in their care was used to find out where improvements were needed and how the service could be further improved. There were systems in place to monitor the service to ensure people received care that was safe and met their needs.

The provider and management showed they were committed to improving the service for people at the home. For example, they expected staff to follow their key value of 'putting life into years' in the way they cared for and supported people as well as how they aimed to develop the service.

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 remains Good	**Good**
Is the service effective? The service remains Good	**Good**
Is the service caring? The service remains Good	**Good**
Is the service responsive? The service remains Good	**Good**
Is the service well-led? The service remains Good	**Good**

Saville Manor Nursing 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.

Before the inspection, we looked at all the information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law.

We read the Provider Information Record (PIR) and previous inspection reports before our visit The PIR was information given to us by the provider. This enabled us to ensure we looked closely at any potential areas of concern. The PIR was detailed and gave us information about how the service ensured it was safe, effective, caring, responsive and well led.

This inspection took place on 30 and 31 May 2017 and was unannounced. The inspection was carried out by one inspector.

We spoke with 18 people who were living in the home and two visitors .Staff we spoke with included the senior manager, acting manager, seven care staff, domestic and catering staff. We also spoke with the provider by telephone after our visit.

We observed how staff interacted with the people they supported in all parts of the home. We also used the 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 looked at care records and charts relating to four people and 11 medicine records. We looked at other

information related to the running of and the quality of the service. This included quality assurance audits, training information for care staff, staff duty records, meeting minutes and arrangements for responding to complaints.

Good

Is the service safe?

Our findings

The provider had been ensuring that allegations of potential abuse were reported to the local authority and to CQC when they needed to. However one recent complaint that could have been considered to be a safeguarding referral had not been reported to the local authority or to us .The provider sent us further information after the site visit. This clearly showed why they had decided not to alert the Local Authority or us about the allegation. The provider, after consultation with the registered manager at the time made the decision that the matter was around a lack of skills and competency rather than a safeguarding matter. The provider had investigated the matter under their own complaints and staff disciplinary procedure and they had taken appropriate action. They had also fully involved the person and their family.

We recommend that the service ensure all staff are trained to know when and how to report safeguarding allegations to external organisations.

To further help to protect people and keep them safe there was a system in place to reduce the possibility of abuse occurring to people at the home. Staff showed that they had an up to date understanding about the different types of abuse that can happen. The staff knew what they needed to do to report concerns about people at the home. The staff told us they were always able to approach a manager if they were ever concerned for a person who lived at the home. Staff told us they had attended training on the subject of safeguarding adults from abuse. Staff told us that the subject of safeguarding people was also raised with them at staff meetings. This was to try to keep staff up to date so that they knew how to raise any concerns and what to do to keep people safe.

Staff we spoke with also knew about the different legislation used to protect people's rights and keep them safe. There was a copy of the procedure for reporting abuse on display on notice boards in several parts of the home. The procedure was written in an easy to understand way to help to make it easy to use. There was also information from the Local Authority advising people how to report abuse.

Staff knew what whistleblowing at work was and how they could do this. Staff understood they were protected in law if they reported possible wrongdoing at work. Staff had also attended training to help them understand this subject. There was a whistleblowing procedure on display in the home. The procedure had the contact details of the organisations staff could safely contact.

Relatives and people repeatedly said that they felt safe and properly cared for living at the home. Comments about staff included, "They are fine and nothing ever goes on like that here." People who could not make their views known also seemed to be really relaxed and comfortable with the staff. This helped to show how they felt safe with them.

The home used a CCTV camera system outside the home. There was a clear policy in place. This had been put in place as a safeguard to ensure that people were safe at the home.

Risks that people may experience were being properly managed to help them to stay safe. An assessment of

the type of risk and what to do to minimise it had been completed and reviewed regularly. There were risk assessments completed for each person in relation to a number of areas related to health and wellbeing. These included the risk of skin pressure breakdown, behaviours that may challenge, moving and handling, falls, and nutritional and swallowing risks. When risk assessments had picked up specific support needs to keep the person safe the care plans clearly set out what to do to ensure this happened. The staff followed the guidance in the risk assessments and cared for people in a way that aimed to keep them safe. This was shown for example, in relation to people's mobility needs, and also in relation to the safest way to support certain people when they were being cared for in bed for health reasons.

People received their medicines safely from the registered nurses on duty. People were given their medicines when they needed them. Medicines were stored and kept in accordance with up to date guidance to ensure this was safe. The medicine records we looked at showed that stock checks were carried out regularly of the amount of medicines n the home. Medicines audits had also been undertaken. These also helped to confirm that medicines were managed safely in the home. We saw a registered nurse give people their medicines on both days of our visit. The nurses explained to people what they were giving them each time and stayed with them while they took them safely.

The provider had devised their own dependency tool to work out how many staff and the qualifications and experience needed at any time. The tool identified how much care and support people needed and by how many staff. A senior manager and the acting manager went on to explain that the numbers of staff that were required to meet the needs of people at the home were increased whenever it was necessary. For example when people were very physically unwell and required extra support and care. The numbers of staff needed were then calculated taking into account each individual's needs. Nurses and care staff were supported in their roles by a number of other staff. These included an administrator, domestic, catering and maintenance staff. Some people needed two staff to assist them safely with their care. The staffing rotas showed the home had the number of staff needed to provide safe care .When there was staff absenteeism this had been planned for and arrangements for other staff to provide cover was in place. This showed how the provider ensured people received care from a consistent number of staff.

To ensure only staff that were suitable were employed all newly employed staff underwent a thorough recruitment process. This was before they could start work at the home and have any contact with people who lived there. Staff had completed Disclosure and Barring checks n place. These were to check if they had any criminal record, which meant they should be barred from working with vulnerable people. The provider also had a staff disciplinary procedure in place. This was in use in case there were concerns around staff practices. This was another way that aimed to keep people safe from the risks from unsuitable staff.

To help to ensure that the premises were kept safe relevant safety and monitoring checks were completed. We also saw up to date certificates relating to gas, electricity and fire safety checks. The home was clean and tidy and smelt fresh in all areas.

To minimise risks from cross infection we saw that staff used protective equipment in the form of disposable gloves and aprons and hair nets when dealing with food. There was an ample good supply of alcohol gel, paper towels and liquid soap in the home. These products also helped with the prevention of cross infection.

Good

Is the service effective?

Our findings

The provider had a system in place for staff supervision for monitoring performance and their development. The provider's own policy set out that staff supervision was to be a process that aimed to develop the staff in their work and overall performance. Supervision in health and social care is defined as an accountable, two-way process. It is aimed at supporting, motivating and enabling the development of good practice. This is to improve the quality of service provided to people. The meetings records we saw for recent staff supervision were reactive and conveyed that only poor performance matters had been raised. For example, concerns raised by staff about others in the team .The notes we read did not convey that the one to one meetings had been carried out in a constructive and positive way. They conveyed that they had been used as an informal disciplinary process. For example, staff were told when they had done something 'wrong' .There was no record of how they were going to learn from it and what support they were given to address any shortfalls in performance such as training needs or what staff were doing well . After our visit the provider did send us further one to one notes for one staff member that were supportive in the way they had been written. However there was still a risk that people were assisted by staff that were not properly supervised, motivated and developed in their work.

We recommend that all staff who supervise others are trained to do so and follow the provider's own procedure.

People received effective support that met their range of care needs. This was evident in a number of ways. Staff used mobility aids correctly and they talked through what they were doing with the person and asked for consent. This was to reassure the person when they supported them. The staff assisted people to have a shower or a bath and to get up. We saw that staff sat people in a comfortable position before they had meals and drinks and when they were in bed. The staff assisted people in an attentive way with their care and support needs. We saw staff were encouraging with people and they were following what was written in each individual's care plan.

To ensure people received effective care staff told us they were allocated a group of people to support in a certain part of the home with their range of needs. Staff told us how this helped them get to know people really well, as well as what sort of care and assistance they preferred. The staff felt that caring for people in small teams was a good way of ensuring they received an individualised service. This was because staff got to know people very well.

People told us they were happy with the food and said that they were always offered meal choices at every mealtime. We observed a choice of water, other soft drinks and snacks also served throughout the day. People were also offered tea and coffee throughout the day. The staff were able to show in conversations with us and by our own observations they understood the different nutritional needs of people. The staff and chef explained that special diets were well catered for. The catering staff were given information from staff when people required a specialised diet and when they first moved in. The staff communicated with people and told them what the food choices were. The staff were organised and they communicated among themselves to ensure everyone had their meal in a timely way. There were menus on display to help people

make a choice from the options to be served.

There was guidance information in care records that set out what to do to support people with their nutritional and dietary needs. An assessment had been completed using a recognised assessment tool. This is a five-step screening tool to identify people who could be at risk of being malnourished, obesity or other dietary linked conditions. The care records clearly set out how to assist people with their particular dietary needs.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager and records confirmed that applications had been made when it was assessed as being in the person's best interest and no other options were available. Staff knew how to support decisions for people in line with the MCA. They explained how they supported people to make decisions that were aimed to be in their best interests and ensure their safety and wellbeing. There were examples of when people's capacity had been assessed. We saw that detailed and situation specific assessments had been put in place. For example, in relation to maintaining safety if a person was to leave the home without support.

Staff were able to tell us how they would seek consent as well as the importance of ensuring peoples' rights being upheld. We heard staff do this before they offered people care and support. The staff we spoke with said they asked and then explained what they were about to do before carrying out care. We saw staff asking people before they carried out any part of their care. People's care records showed they had signed consent to care where able to do so. Families were involved when people were not able to sign their care plans and be involved in planning their care.
The staff team had been on Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) training. The Mental Capacity Act 2005 is a legal framework to support decisions to be made in the best interests of adults who do not have the capacity to make an informed decision. There was guidance available about the Deprivation of Liberty Safeguards Law (DoLS). This information meant staff could get hold of guidance, if needed to ensure safeguards were in place to protect people in the least restrictive way. This information also helped to inform staff how to make a DoLS application.

Training records showed there was regular training available for staff. Sessions staff had been on included nutrition, wound care, and medicines management. This was to ensure they had the skills and knowledge to effectively meet people's needs. Staff told us they had been on an in depth induction programme before they began working at the home. The induction programme included learning about different health and safety practises and procedures, the needs of older people, safeguarding people from abuse, and correct moving and handling. They were also inducted about the needs of people who lived at the home and how to meet them. We spoke with recently employed staff who told us they had completed an in-depth induction programme and this had included working alongside experienced staff learning how to provide good care.

Good

Is the service caring?

Our findings

We saw staff use positive interactions with the people they supported. We saw how this helped to create a positive culture where people felt valued and cared for by the staff. People told us that they felt valued by staff. They also said staff took a "genuine interest" in getting to know them as people and that this made them feel the staff cared about them.

Staff used respectful approaches with people. For example they discreetly assisted people who needed support to maintain their dignity. We saw that staff knocked on bedroom doors before entering bedrooms. When staff were supporting people with personal care doors were closed and these actions also protected their dignity. We also saw how staff spoke to people with respect using the person's preferred name.

Staff also used gentle warm humour with people. People told us enjoyed a laugh and a joke with the staff. Staff offered people comfort and this was well received, they held people's hands, maintained eye contact with them and held and hugged people when requested. Staff were attentive to people and their moods When people looked sad or anxious staff were quick with these comforting approaches. Staff were aware of people who could get anxious. Staff gave support and reassurance to them.

Staff told us some people did not like this kind of interaction and they used a totally different approach with them. People responded warmly to these conversations with the staff .People were assisted to get up at different times during the day. People ate their meals at times of their choosing and sat where they wanted to in the home. These ways of supporting people were all reflected in individuals care plans.

Staff understood what personalised care was. They told us it was one of the key values that the provider had. It meant they must always try to put the person at the centre of how care was planned for them. It also meant making sure people were cared for in the way they wanted to be. For example, choosing when they would like to get up, the gender of staff supporting them with intimate care, and what sort of meals they wanted.

The staff felt they provided a caring service. One staff member said they aimed to treat people as their family would like to be looked after. Another staff member said they were always being reminded to treat people as if they were staying in a hotel.

Staff had a good insight and awareness of the likes, dislikes and the care needs of each person they supported. Care records had a personal history section that gave each person's life history and experiences. These were documented in clear detail. This information gave staff essential facts and past experiences about people. They staff said they used this information to form a detailed account of people's life experiences, preferences. This also helped ensure people received personalised care.

People had their own bedrooms and this meant that they were able to have time in private if they wanted it. The bedrooms we saw were personalised with some of the person's belongings. People could bring photos and small items of furniture in to them to make them feel more homely. There were quieter lounges that

people could also use if they wanted to meet with visitors.

People were being supported on end of life care at the home. Care plans set out how to provide people with palliative care and support. We saw staff assisting people sensitively at this time. Care records also included preferences for people around end of life care wishes. These wishes were reviewed regularly and they included people's preferences and wishes for preferred place of care and specific funeral arrangements. Staff we spoke with knew peoples wishes. Some staff had been on end of life training. This meant staff knew how to provide care to people who were nearing the end of their life.

Good

Is the service responsive?

Our findings

Staff were knowledgeable about people's individual care needs and were able to explain how they used the care plans to ensure care was given in the way the person preferred. Care plans were comprehensive and personalised. They contained detailed information and reflected how each person wished to receive their care. Care records also gave guidance to staff on how best to support people. We read about people's likes, dislikes and preferences. These included what type of support they preferred with personal care, as well as their bed time and morning routines. Care records were being reviewed regularly where possible with the involvement of the person who they were written about. The care records contained detailed information and reflected how each person wished to receive their care. Care records also gave guidance to staff on how best to support people with more complex nursing needs. These included plans of care for people who needed dressings, and for people who had more complex mobility needs.

Staff assisted people with their care in the ways that were set out in their care plans. Plans had details of people's likes, dislikes and preferences. These included how often and when they wanted support with personal care, and their bed time and morning routines. Care records were reviewed and updated regularly, where possible with the involvement of the person they were written about. Staff told us their role was to assist people to complain and make sure management heard their views.

The home was set in its own gardens with a view out onto a large park area. People told us how in recent hot weather they had sat outside and had tea and enjoyed this activity. The full time activities co-ordinator who was employed to facilitate a varied activities programme had very recently left. A number of people commented to us about how they enjoyed the activities that were provided? The senior manager told us a new full time activities organiser was about to start at the home. They were known to the home and had worked there previously as well. Other activities included visits from external entertainers and outings during the warmer weather. Church services were held regularly which helped to ensure certain people's spiritual needs were respected.

There were a number of systems in place to help people to be able to actively make their views known about the care and support they were receiving and life at the home. People were asked for their suggestions for social events, therapeutic activities and the menu choices. A newsletter for people using the service and their relatives was produced on a regular basis. Subjects that were covered included updates about recent events that had occurred, dates for residents meetings and outings. New staff were also interviewed and birthday celebrations were acknowledged as well. Relatives meetings were also held at the home. We saw dates of future meetings planned for different times and days of the week including weekends to make them more convenient for people to attend. There was a suggestions book prominently displayed in the hall way of the home .People were invited to make confidential suggestions this way if they preferred

A service user and relatives survey was carried out on an annual basis. The results were analysed by the provider. The most recent survey had been very positive. However action plans were put in place to improve the overall service People knew how to complain and we saw that that their complaints would be resolved constructively. There was a complaints procedure in place that explained how the registered manager

would respond and investigate any complaints and address them promptly and openly. The procedure also explained how suitable actions would be put in place to address complaints raised.

Good

Is the service well-led?

Our findings

The staff said that the provider was respected and was supportive to them. The senior manager told us how they were going to be supporting the new acting manager to help them clearly understand their roles and responsibilities. They said they had worked with the acting manager before and they already had a close working relationship.

The senior manager conveyed to us that they were providing effective leadership at the home in the absence of a registered manager. They had knowledge, enthusiasm and insight into the home, the people who lived there and the team. The staff knew what the provider's vision for the service was. They shared the vision for providing the best quality of person centred care. This ensured the vision and values were put into practice.

The quality of service and overall experience of life at the home was being monitored. Areas being regularly checked included the quality of care planning processes, management of medicines, staffing levels and training. Quality audits had identified that there were shortfalls in the management of medicines that need to be returned to a pharmacist. Actions had been identified to address this area. When shortfalls were identified, we saw the registered manager had devised an action plan to address them.

The provider also used an outside assessor to check quality and safety in the service. After the external consultant had completed one of their assessments the previous registered manager had to complete an action plan. This was to set out how they would address shortfalls in the service. For example the last assessment in early 2017 had identified a need to review infection control practices and procedures. The previous registered manager had written an action plan and stated this would be for all staff to action and address. The previous registered manager had not completed their review to see if the necessary improvements to the service had been made. This was being followed up by the senior manager we met and the acting manager. This was to ensure that improvements from those actions that had been identified as being needed had been effective. This was also to make sure that the service continued to improve and drive up standards and overall quality.

There was a system for recording accidents and incidents which involved people living at the home. These were analysed and learning took place. The manager and provider acted when any trends and patterns had been. Actions were put in place to minimise the risk of re-occurrence. For example, we read about one person who had experienced several falls from their bed. We saw guidance was in place from other health and social care professionals to offer the person specialist advice to reduce the risks from falls in their room and in the home.

The staff had a good understanding of the provider's visions and values. They explained that they included being person centred with people, supporting independence and treating them with the upmost respect at all times. The staff told us they tried to make sure they always used and followed these values when they assisted people. For example, staff said they helped people to make choices in their daily life in relation to their care.

Staff meetings were held on a regular basis and the team told us they were readily able to make their views known to the manager. We saw records of recent minutes of staff meetings. These were used as an opportunity to keep staff informed about changes and about how the home was run. Staff were also offered the time to make their views known.

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