Sirona Care & Health C.I.C.

Combe Lea Community Resource Centre

Inspection report

Combe Lea Residential Care Home
Greenacres, Midsomer Norton
Radstock, Bath
Somerset
BA3 2RD

Tel: 01225396616

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27 September 2016

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Combe Lea Community Resource Centre. is registered to provide accommodation and personal care for up to 30 people. On the day of the visit, there were 30 people at the home.

There was a registered manager for 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 the last inspection in June 2015, we asked the provider to take action to improve some areas of the service. This was in relation to the system for managing people's medicines that was not fully safe. People's personal care needs were not always identified. Care plans did not always show how to support people in a way that met their needs. We had also found that the system of supervision to support staff effectively in their work was not up to date. There was also a lack of meaningful activities for people to take part in.

The provider had made some improvements in relation to providing social and therapeutic activities.

Some improvements had been made in relation to care records. Care plans had more detail and were more informative about people's care and support needs. However, some assessments, that identified what level of support people needed had not been completed or regularly reviewed. This meant there was a risk that staff may not know what peoples current needs were or how to support them.

Improvements were needed in relation to the safe storage of some medicines. Some medicines had not been stored securely. Staff supervision was still not being provided regularly to all staff. Some staff had had recent one to one meetings with a supervisor but there were gaps of up to six months when staff were not being formally supervised. This meant staff were not consistently guided and supported to fulfil their job roles effectively.

The majority of staff told us that they felt distant from the management of the service .They said the registered manager was kind and helpful when they did see them. However, staff said they did not see the registered manager on a regular basis.

Although quality audits identified shortfalls in the service such as medicines storage being unsafe actions had not been taken to address these matters.

The staff knew people they looked after well and were aware of their likes, dislikes and personal circumstances. However, we found that the guidance and information provided about people's backgrounds, life histories, cultural and religious beliefs was not always detailed or fully completed. This information is useful in ensuring staff see each person as a unique individual.

Staff understood their responsibility to protect people from avoidable harm and potential abuse and knew how to report concerns. There were processes in place to ensure that staff were trained to care for people and suitable to work within a caring environment.

We found that people were given their medicines safely at the times that they needed them. Medicines were reviewed regularly by their doctor to make sure they were still suitable.

People had their needs met by enough staff. There was some use of agency staff and 'bank' staff who work for the provider. These are staff who work at the service on an occasional basis. The provider had a recruitment and retention strategy in place to employ and keep more staff.

People said that they liked the food and we saw they were offered choices at each mealtime to help them decide what option they wanted. People spoke highly of the staff team that supported them. They told us that they were kind and that they worked hard.

The service was meeting the requirements of The Mental Capacity Act 2005 (MCA). Assessments of capacity had been undertaken and applications for Deprivation of Liberty Safeguards (DoLS) had been made to the relevant local authority. The staff asked for consent before carrying out care

There were detailed mental capacity assessments specific to areas of each individual's daily life in place. These protected the rights of people who did not have the mental capacity to make informed decisions.. For example, certain people sometimes declined any assistance with personal care despite needing staff support.

Staff were caring and courteous toward the people they supported and had built up close and caring relationship's with them. We saw staff supported people in a way that ensured that privacy and dignity were respected. Staff provided people with explanations and information so they could make choices about aspects of their lives.

People were encouraged to be included in deciding how they wanted to be supported with their care needs. The families and other representatives of people were involved in decision-making. This was when it was felt to be in the best interests of the people concerned.

People were supported by a team of trained staff. The majority of staff had been on training that was specific to understanding the needs of older people. The staff had also attended a variety of other regular training in health and safety topics .This helped them to improve and develop their skills and competencies.

People and those who represented them were supported to be able to complain and make their views known. The provider sought the views of people and their families. Feedback about the home from people and others involved in their care was positive.

During this inspection, we identified four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Medicines for some people were not stored safely .People received their medicines at the times they were needed.

Staff were recruited safely and there were sufficient numbers of them to meet the needs of people at the home.

Staff had received safeguarding training and understood how to keep people safe from the risk of harm and abuse.

Risks assessments were in place to guide staff to provide people with safe care.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective

Staff were not properly supported and supervised in their work. This meant there could be a risk that care was not safe or suitable.

Staff received training that helped them to do their jobs effectively. The staff had the knowledge and skills to provide support to people that met their needs.

People enjoyed the meals and were offered a choice at mealtimes.

Staff knew how to ensure they promoted people's freedom and protected their rights because they complied with the requirements of the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

People were supported by a team of staff who were kind and caring towards them. Staff used caring open body language to communicate with people.

Staff knew people well and had a good awareness of their individual choices and preferences.

Staff supported people in a way that ensured their privacy and dignity were maintained.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive

Some assessments of people's needs were not completed or regularly reviewed. This meant there was a risk that staff may not know how to support people.

Care plans showed what actions were needed to meet the needs of people.

People were being supported to take part in social and therapeutic activities. Many informal activities happened during the day with people.

Is the service well-led?

Requires Improvement

The service was not well led

The majority of staff felt that they did not see the registered manager on a regular basis.

Staff said that the registered manager was kind and caring.

Quality checking audits were in place that identified shortfalls in the service. However, these were not acted upon such as in relation to shortfalls in medicines storage.

Staff knew what the visions and values were of the service and were able to explain how they followed them when they supported people.

Combe Lea Community Resource Centre

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 26 and 27 September 2016 and was unannounced. The inspection was carried out by one inspector.

We 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 observed care and support in communal areas and staff interaction with people during a mealtime.

We met 21 people who were living in the home, and two relatives .Staff we spoke with included a senior manager, four senior support workers, and six support workers and catering staff. We observed how staff interacted with the people they supported in all parts of the home. The registered manager was on leave when we visited .

We looked at three peoples care records, seven medicine records ,staff training records staff recruitment files, supervision records and staff duty rotas. We also checked a number of other records relating to the way the home was run. These included a copy of the provider's recruitment and retention strategy to employ and keep staff.

Requires Improvement

Is the service safe?

Our findings

Medicines were not always stored safely. A keypad safe that was used to store some medicines securely was broken. Staff were using a key to open the safe. However, this key was kept in a drawer in one of the offices and the office was not locked on the days of our visit. A health and safety audit in April 2016 had identified that a medicines safe was not working properly and the unsafe practise of staff with the key had been identified as a risk. On both days of our visit, staff were still leaving the key in the drawer in an office that was frequently unlocked and unoccupied. This meant there was a risk that medicines could be stolen or used inappropriately. This in turn could mean people may not have in stock at the home the medicines that they need. The senior manager told us that action was being taken to address this after our visit .

This was a breach of regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines that required additional security were regularly checked by staff. There were daily records of the fridge and room temperatures to ensure medicines were stored at the temperatures needed to maintain their effectiveness. There were guidelines in place for people who had medicines prescribed to be taken as and when required, for example to help people manage their pain. Body maps were in place in care records to guide staff when to apply creams and lotions. This helped to ensure people were given their medication safely.

We saw that people were safe with the staff at the home. The staff also assisted people with their needs safely. For example if people needed support with their mobility needs this was done by staff who used safe techniques.

The senior manager told us the numbers of staff that were necessary to meet the needs of people at the home could be increased if required. For example, if people were physically unwell and required extra support and care. The number of staff needed to meet the care needs of each person was worked out by taking into account each individual's needs. Support staff and care staff were supported in their roles by a range of other staff. These included an administrator, domestic, catering and maintenance staff.

Staff had a good understanding about the different types of abuse that could happen to people. Staff told us they had been on training about the subject of how to minimise the risk of harm and abuse. The staff were able to give us examples of what they would lookout for, the actions they would take and how they would report their concerns.

Staff also knew about the legislation in place to protect people's rights and aim to keep them safe from the risk of abuse. There were copies of the procedure for reporting suspected abuse on display on notice boards in several parts of the home. The procedure was written in an easy to understand style to help to make it easy to use. There was also information from the local authority about how to report suspected abuse if they were concerned about someone.

The registered manager reported all concerns of possible abuse to the local authority and told us when they needed to. 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 people could safely contact.

People's needs were assessed and risks identified in relation to their health and wellbeing. These included risks associated with moving and handling, falls, nutrition and pressure area care. The home had been part of a falls prevention project. This meant the service was focused on supporting people to avoid harm from falling. Risk assessments were reviewed monthly. One person's falls risk assessment identified the need for closer observation and extra safety equipment.

There was a recruitment procedure in place that helped reduce the risk of unsuitable staff being employed. New staff were only employed after a number of checks had been completed. These included references, proof of identification and criminal records checks. Staff we spoke with told us they had undertaken these checks. Disclosure and Barring Service (DBS) checks were carried out on all the staff. We found proof of identification in the form of passports, were also checked for all staff. The DBS is a national agency that holds information about criminal records. This helped to ensure people who lived at the home were protected from individuals who had been identified as unsuitable to work with vulnerable people.

Health and safety systems were in place to keep the environment and equipment safe. For example, a fire risk assessment had been undertaken. There were contracts in place with external companies to check firefighting equipment and fire detection systems. Moving and handling equipment such as hoists were regularly checked and maintained in working order. This meant people had safe equipment to support them with their mobility needs.

The premises looked clean and tidy in all the areas that we viewed. We saw domestic staff working hard cleaning the home on both days of our visit. People told us that domestic staff cleaned their room every day. Staff and records confirmed that they had completed training to help them follow safe practices and procedures in relation to infection control.

There were systems in place to reduce risks from cross infection. Care staff, housekeeping and laundry staff helped maintain a hygienic environment. Housekeeping staff had a colour coding system in place for their cleaning equipment. This minimised the spread of potential infection. For example, cleaning equipment used to clean toilets was not used to clean bedrooms and communal areas. The staff wore protective plastic gloves and aprons when giving personal care. This was to reduce the risk of cross infection.

Requires Improvement

Is the service effective?

Our findings

At our last inspection, we found that the system of supervision to support staff in their work was not up to date. At this inspection, we found that staff supervision had not been kept up to date. Staff supervision is a system that aims to support staff and help them improve how they are performing in their role. The records we saw showed that staff were not receiving regular, on-going supervision sessions. For example, we saw in one staff member's record that they had received two supervision sessions during 2015 and two during 2016. In another record, we saw that the member of staff had received one supervision session during 2015 and two during 2016. Ina further staff member's record we saw they had received two supervision sessions during 2015 and one during 2016. The provider had a policy that set out that staff should receive a structured supervision session with a named supervisor at least every six weeks. The staff told us that staff supervision meetings did not happen regularly. This meant that staff were not receiving appropriate support and guidance to enable them to fulfil their job role effectively. Staff were being supervised by different senior members of staff. There was no evidence that issues that were identified at a supervision session were followed up at the next meeting that was held with staff. Staff had an appraisal with a supervisor to review their overall performance over the previous year. However, the records of these appraisals were minimal. There was a lack of evidence that the overall quality of a staff member's work had been reviewed with them in an in depth and meaningful way.

This was a breach of regulation 18 2 (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff went on a detailed induction programme before they commenced working at the home. The 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.

The staff team had attended Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) training. There was guidance available about the Deprivation of Liberty Safeguards (DoLS). This information meant staff could access 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.

Staff understood how to obtain consent and the importance of ensuring people's rights were upheld before they offered them 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.

People were provided with effective support with their 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.

Arrangements were in place for people to receive the services of opticians, dentists and chiropodists. Care records showed that people received support and services from a range of external healthcare professionals. These included doctors, district nurses and chiropodists. Staff maintained records of specialist involvement.

People were happy with the food and told us they were always offered choices at each mealtime. We observed lunchtime in the home, people ate where they chose to and this included the dining rooms, lounges and their own rooms. People who required assistance to eat were appropriately supported by staff. Some people living with dementia were prompted and encouraged to eat. A choice of meal was available. There were menus available to help people make a choice from the options available. We saw a choice of water and other soft drinks were available. People were also provided with tea, coffee and other drinks throughout the day.

The catering staff were helped to understand people's different nutritional needs and special diets were catered for. They were given information from staff when people required a specialised diet. Catering staff also kept nutritional records to show when people had any specialist needs or dietary requirements. For example, people with diabetes and people who needed to increase weight were provided with suitable diets. Information in the care records set out how to support people with their nutritional needs. An assessment had been undertaken using a recognised assessment tool. This is a five-step screening tool to identify adults, who were malnourished, at risk of malnutrition or obesity. The care plans clearly showed how to assist people with their particular dietary needs. For example, certain people needed a diet that was of high calorie content and this was provided for them.

The staff ensured that monitoring charts were properly completed to record any staff intervention with a person. For example, these recorded when and how much people had eaten, and how much fluid they had consumed. Records were also in place for people who needed assistance to be repositioned so that their skin did not break down.

Good

Is the service caring?

Our findings

People were cared for and supported by staff who were caring and kind in their approach towards them. Staff were friendly, polite and respectful and spoke to people with a caring manner.

We saw that when people needed support with personal care such as bathing and washing they were prompted discreetly by staff who gave them support.

The staff were warm, patient and kind with people when they supported them with their care. They knelt beside people when supporting them and offered reassurance. We observed one staff member gently stroking a person's hand and speaking gently to them. One person had become anxious and said they wanted to leave. A support worker sat down with them and spoke to them kindly, suggesting they should have a cup of tea before they left. This reassured and relaxed the person, and the cup of tea had distracted them from leaving the home at that moment.

We observed staff interacted with people in a kind, respectful and personalised way. This was evident to us in a number of ways. For example, numerous staff members sat beside people while talking and gently laughing with them. Other staff members were observed comforting people who had become distressed, speaking in a gentle tone with the person and gently touching their arm or giving them a hug.

We saw that each person we met looked very smart and dignified in their clothes and accessories. These activities and observations demonstrated that people were being supported in a caring way with their needs.

Some people preferred not to mix with other people and liked to spend time in their rooms. Staff supported people in their rooms. We saw they popped in on them regularly to see how they were.

People told us that visitors were always made welcome in the home and this meant people could see their friends and family when they wanted. We saw staff greet visitors in a warm and welcoming way. Staff offered visitors a drink and if people wanted a quiet room to spend time with visitors this was arranged for them by the staff.

People had their own bedrooms and this meant that people were able to spend time in private if they wished to. The bedrooms we viewed had been personalised with some of the person's belongings. We saw people were able to bring photos and small items of furniture in to them to look more homely.
Staff we spoke with described and gave examples of how they treated people with respect. Staff said they ensured people were covered if assisting them with their personal care. They also said they always offered people choices in everything when helping them. For example, what clothes did they want to wear, and did they want a bath or a shower.

Staff knew what the idea of person centred care was. They told us it meant 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 preferred.

For example, choosing what time they got up, what gender of staff supported them with intimate care, and what choice of meals they wanted. Staff also used respectful language for example they referred to helping people at lunch times as assisting people with meals

The staff knocked on bedroom doors before entering people's rooms. When staff were providing personal care people's doors were closed and these actions protected their dignity. We saw how staff spoke to people with respect using the person's preferred name.

Each person had their own keyworker who was a named member of staff. They were responsible for ensuring information in the person's care plan was up to date and they spent extra time with people individually.

People's records showed that their preferences, and wishes about their end of life care were discussed with them or their relatives. People had recorded decisions about the circumstances in which they would prefer to receive resuscitation and hospital treatment and when they had chosen not to. People who had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision in place were identified in their care records. Medicines were made available if needed to support people at the end of their life.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection, we found people's personal care needs were not always identified and care plans did not always show how to support people in a way that met their needs. We also found that there was not enough for people to do because there was a lack of social and therapeutic activities for them .At this inspection we found that that each person had a care plan in place that set out how to meet their needs. Staff were knowledgeable about people's individual care needs and were able to explain how they read the care plans to ensure care was given in a way that met the person's needs.

Care plans contained a section to complete a life history about the person .These had not been completed for the people whose care plans we read. This meant they lacked a person centred approach in the information that they contained. In addition, monthly reviews monitored people's progress and allowed people to have a set time each month to discuss their needs. Care plans covered areas such as continence, hygiene, mobility, nutrition, medicines and activities. These set out how often and when the person wanted support with personal care, and their bed time and morning routines. However, assessments of people's needs had not always been completed or regularly reviewed. An assessment is a tool that helps to identify how much care and support a person needs. One person who had a care plan that showed they had specific nutritional needs did not have a completed assessment tool of their nutritional needs. This meant there was a risk that the care plan was not accurate or up to date. The skin conditions assessment for a person who was being cared for in bed had not been reviewed for two months. This person's care plan showed they were at risk of skin breakdown. There was a risk that the person may not be supported effectively if their assessment of their skin integrity was not regularly reviewed to ensure it was up to date.

People had a range of activities they could be involved in. Activities available included outings and group based activities such as quizzes, crafts and musical events and individual activities such as; massage and puzzles for people who preferred or needed individual support. People told us they enjoyed the activities on offer. Some of the activities focused on reminiscence therapy, such as singing songs from the past and quizzes based on past events. People were also encouraged to engage in sensory activities that can support people living with dementia to access memories. This included massage, crafts and gardening. The home had a garden area and part of this was used by people to take part in gardening activities. Care records showed that people participated in a range of activities to meet their social and spiritual needs and their interests. Photos of activities were on display in the home.

The provider had a complaints procedure and this was displayed in the home. We reviewed the record of complaints that showed they had been responded to. People and their relatives told us that although they had not raised a complaint they knew how to do so and were confident staff would listen and respond. There had been no complaints since our last visit. We saw complaints would be dealt with promptly in line with the provider's policy. People were actively encouraged to make their views known about the service. For example, people and families were asked for their suggestions for activities and the meal choices. Relatives meetings also took place at the service.

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 prepared to improve the overall service. There was also a suggestion box in the entrance area and a sign that encouraged people to complete a survey about the home. This meant the registered provider welcomed comments about the service people received.

Requires Improvement

Is the service well-led?

Our findings

The systems to assess, monitor and improve the quality of service had not addressed the risks relating to the health, safety and welfare of people who used the service. While there were structured processes in place for regularly auditing the care and overall service, these were not always acted upon by the registered manager or the registered provider. For example, some electrical equipment needed to be tested to ensure it was safe and this was highlighted in a health and safety audit. However, this had not been acted upon as for some electrical items this test was still out of date. A medicines audit had picked up that medicines were not stored safely on one floor of the home. This was in April 2016 and had not yet been actioned. Audits had also identified that staff supervision was not being carried out regularly and consistently and that assessments were not all up to date. However, this had not been addressed.

This was a breach of regulation 17 (2) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The majority of people we spoke with were not aware of who the registered manager was. One person did say, "They seem very nice." The staff team spoke of feeling distant from the management of the service. Every staff member said that the registered manager was "nice "and "supportive". However, staff said they did not see them on a regular basis. For example, staff explained that the registered manager would "walk the floor at the start of a shift and at the end of a shift". This lack of management presence could affect the quality of care. It could also impact in a negative way on the morale of staff. The registered manager is responsible for monitoring and improving standards of care. Their role also includes leading and motivating their staff team.

The provider used an online system of recording accidents and incidents which involved people living at the home. These were analysed and learning took place. Trends and patterns were identified, actions were put in place to minimise the risk of re-occurrence. For example, guidance was in place from other health and social care professionals to offer the person specialist advice. This information was available online to everyone in the organisation who needed to view it .The staff said this information was used by them and by the provider to monitor the quality of care people received. For example, a senior manager checked if people had received care and support that they needed in a timely way, and by the correct number of staff. We saw that care records had been changed and updated based on this information.

Staff meetings were held and the team told us they were able to make their views known to the registered 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 given plenty of time to make their views known. This showed there was an open management culture.

The staff understood the provider's visions and values. They told us they included being person centred, supporting independence and respecting their diversity. The staff told us they aimed 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

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Assessments were not always completed or updated . This put people at risk of receiving unsafe care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not stored safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Shortfalls in the quality of the care and service identified in audits were not always addressed

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not being appropriately supported and supervised in their work to enable them to carry out the duties effectively.