HC-One Limited

County Homes

Inspection report

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Date of inspection visit:
14 August 2018
15 August 2018

Date of publication:
18 September 2018

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

This inspection took place on 14 and 15 August 2018 and was unannounced.

County Homes is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The home is registered to provide personal care and nursing care for up to 90 people, however the manager told us that the maximum number of people accommodated is now 82 because a number of rooms were registered for double occupancy but are no longer shared.

The home is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The home had a registered manager who had been in post for several years.

The manager told us that all of the people accommodated were living with dementia and required nursing care. The home was divided three units known as Chester, Lancaster and York. Each of these had a unit manager. Each unit was further divided between ground and first floors, which meant that the maximum number of people living in each area was 14. Each area had its own lounge and dining room. Three areas accommodated men only and two accommodated women only.

At our last inspection of County Homes in July 2017, we found a breach of Regulation 9 of the Health and Social Care Act: Person-centred care, because care plans did not always provide sufficient details to enable staff to meet people's needs safely, and planned care was not always evidenced as provided. During this inspection we found that improvements had been made to the care plans and there was no longer a breach of regulations.

Relatives we spoke with told us that they felt their family members were safe in the home and that they had no concerns regarding their care. They told us the staff were kind and caring and protected the dignity and privacy of people living in the home. Visiting relatives were made welcome and were encouraged to be involved in the care and support of their loved one.

Staff were recruited safely. Staff were supported in their role through an induction, supervisions and an annual appraisal. Training was provided to ensure staff had the knowledge and skills to meet people's needs.

People's medicines were managed safely.

Applications to deprive people of their liberty had been made appropriately. Records showed that consent was sought in line with the principles of the Mental Capacity Act 2005.

Feedback regarding meals was mainly positive, however there were some room for improvement. Staff were knowledgeable about people's individual nutritional needs and preferences.

A range of social activities was provided to keep people stimulated and occupied.

The manager and the area director completed regular quality monitoring audits which identified any areas needing improvement. Action plans were agreed and implemented by the manager and the staff team.

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 medicines were stored and handled safely.

There were enough staff to meet people's support needs and robust recruitment procedures had been followed to ensure that new staff were of good character.

Maintenance records showed that regular checks of services and equipment were carried out by the home's maintenance team, and testing, servicing and maintenance of utilities and equipment was carried out as required by external contractors.

Is the service effective?

Good

The service was effective.

People's individual dietary needs and choices were catered for and their nutritional status was monitored.

The home complied with the requirements of the Mental Capacity Act.

Staff received regular training and supervision to ensure they knew how to work safely and effectively.

Is the service caring?

Good

The service was caring.

We observed that staff protected people's dignity and individuality by respecting their choices and preferences. Staff treated people with kindness and respect.

People's relatives were made welcome when they visited and were involved in their care.

People's personal information was kept securely to protect their confidentiality.

Is the service responsive?

Good

The service was responsive.

The care files contained comprehensive assessments and plans that were updated monthly.

A range of social activities was provided to keep people stimulated and occupied.

The home's complaints procedure was displayed and complaints had been addressed appropriately.

Is the service well-led?

Good

The service was well led.

The home had a manager who was registered with CQC.

Regular meetings were held for staff and for the families of people living at the home.

The manager completed a series of quality audits which were accompanied by action plans for improvement as needed.

County Homes

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 14 and 15 August 2018 and was unannounced on the first day. The inspection team consisted of an adult social care inspector, a specialist professional advisor (SPA), 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. The SPA was a registered nurse who specialised in supporting people with mental health needs.

Before our inspection we looked at the information CQC had received about the service including notifications of incidents that the provider had sent us, complaints and safeguarding. We contacted the local authority to ask if they had any concerns about the service.

During our visit to the service we spoke with eight people who used the service, 11 visiting relatives, and 13 members of staff including the manager and the area director. We observed care and support in communal areas and staff interaction with people. We looked at six people's care records and records relating to health and safety, staff, and the management of the service.

Good

Is the service safe?

Our findings

We walked all around the premises and saw that the environment was clean and well-maintained. The home had a full-time and a part-time maintenance person and maintenance support was also available from a nearby service and a 24 hour help desk. The maintenance team kept records of regular checks and tests they carried out. The monthly checks included water temperatures; profiling beds, emergency lighting and fire safety equipment. Contracts were in place to check the gas, electrics, nurse call system, lifting equipment, passenger lifts and fire safety equipment. The certificates for these checks were all in date.

A fire risk assessment of the building had been carried out in 2017 and the improvement actions identified had all been addressed. Regular fire drills were held. A detailed personal emergency evacuation plan was in place for each of the people living at the home and there was an evacuation plan for each unit.

Eight housekeeping staff were employed to cover cleaning and laundry duties. A visitor told us "It's very clean, they're always cleaning." We visited the laundry and found that it was clean, tidy and well organised. The kitchen had a five star food hygiene rating.

Nursing staff completed risk assessments to assess and monitor people's health and safety. Risk assessments covered areas including falls, nutrition, mobility, choking, dependency and skin integrity. The assessments were reviewed regularly and appropriate measures put in place based on the outcomes. We saw very good reporting and recording of accidents and incidents, with a monthly summary completed by the home manager. Monthly reviews identified any themes or trends with the aim of reducing the risk of recurrence.

The manager told us there were usually two nurses and four care staff on each unit during the day and one nurse and three care staff on each unit at night. The home had developed a nursing assistant role, which involved senior care staff undertaking additional training to enable them to support the nurses on duty with medicine administration, catheter care, taking blood and monitoring people's wellbeing. At times there was a nurse and a nursing assistant on a unit rather than two nurses.

During our inspection we did not see staff rushing around, or people having to wait for attention. Some of the staff we spoke with told us there were enough staff on duty, however on one of the units, two members of staff felt strongly that an additional member of staff was needed. We discussed this with the home manager and the area director. They told us that they implemented a dependency assessment of people living in the home to help determine how many staff were needed. This, plus other quality assurance checks, had not indicated that additional staff were needed. However, they assured us that the dependency assessment was kept under review and additional staffing would be provided if needed.

In addition to the staff rota, five people had been assessed as requiring one to one support to maintain their safety and well-being. For four of these people, the staffing was arranged by the Clinical Commissioning Group and the support was provided by agency staff. There was also some use of agency staff to cover shortfalls in the staff rota. The home's administrator had records of the agency staff who worked at the

home, including their Disclosure and Barring Service number and a summary of their training. The records showed there was some continuity of personnel and that new agency staff had an induction to the home.

We looked at personnel files for four new members of staff. The records we checked showed that robust recruitment procedures had been followed before any new staff started working at the home. This ensured that staff working at the home were of good character.

Staff we spoke with were knowledgeable about safeguarding and how to raise any concerns. A policy was in place to guide staff on actions to take in the event of safeguarding concerns and details of how to contact the local safeguarding team were available in the entrance area. The home manager made appropriate safeguarding referrals to the local authority and notifications to CQC.

Medicines were stored securely in locked clinic rooms on each unit and temperatures of the rooms and medicines fridges were monitored and recorded to check that medication was stored safely. Controlled drugs were stored in a separate locked cupboard and the balances checked twice daily on shift handovers. Medication administration records had been fully completed and reflected that the stock balance of medicines was checked at each administration. Administration protocols were in place for medication prescribed to be given 'when required' to help ensure people received their medicines in a consistent way when they needed them.

Good

Is the service effective?

Our findings

The care files we looked at showed that people living at the home were supported by health professionals including GPs, dentist, optician, dietician, speech and language therapist and wound care specialist nurse. A GP from the local surgery carried out regular visits twice a week. During the inspection we spoke with the GP who told us the system worked very well in preventing hospital admissions and supporting end of life care. He also considered that the home's nurses knew people well and "know what they're doing". Records we looked at showed that a person who had skin and tissue breakdown was visited regularly by the wound care specialist nurse.

The Mental Capacity Act 2005 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The home manager told us that, because all of the people accommodated at the home were living with dementia and all had been assessed as requiring nursing care, a DoLS application was submitted to the local authority when people went to live at the home. People were not free to leave the home on their own and were under constant supervision. The manager maintained a record of DoLS applied for, when they were authorised, and when they were due to expire. There was also a record of Powers of Attorney that were in place to enable a relative, or other authorised person, to make decisions on behalf of a person living at the home.

We saw assessments in people's care files regarding consent. Some people did not understand the consequences of refusing medicines and essential medicines were given to them covertly ie disguised in food or drink. This process was well documented and a care plan was in place to guide staff how to administer the medicines. Staff we spoke with told us they always asked people for their consent before providing support and we observed this during the inspection.

The manager told us that the use of restraint was minimal, for example bed rails were not used in the home, however restraint may sometimes be necessary to keep people safe and/or to enable essential personal care to be given. Following the inspection, the manager sent us a copy of the provider's Violence and Aggression at Work procedure which advised staff how incidents should be dealt with and recorded.

Training was provided to support staff in their roles and help ensure they had the knowledge and skills required to meet people's needs. Records showed that training was provided in areas including moving and handling, infection control, safeguarding, equality and diversity, person centred care, fire awareness and food safety, and was updated regularly. Records showed that new staff completed a full programme of

induction training. There were opportunities for care staff to progress to senior and nursing assistant after they completed a national vocational qualification (NVQ) in care and further training. Records showed that staff received regular supervisions and an annual appraisal to monitor their performance and well-being.

We observed lunch being served in the dining rooms of each of the six living areas. The tables were set with cloth tablecloths, napkins and condiments. People were offered a choice of meals and drinks. The atmosphere was pleasant and calm; no one was hurried and the staff were patient. People could eat their meals in the dining area, their bedroom or one of the lounges. Some people were given assistance with eating, however staff told us that some people did not like to be helped with their meal.

Staff were aware of people's individual support needs regarding meals, for example they told us that one person sometimes did not eat all day, but enjoyed their breakfast, so they ensured the person always had plenty of breakfast. There was a small kitchen on each unit for drinks and snacks and this ensured that food was available for people 24 hours a day.

People's opinions regarding the meals were mixed. Some relatives told us "She seems to like the food." and "The food's fantastic, I had Christmas dinner here and it was lovely."; while others were less positive and said "The food's not so appealing." and "Hospital food's better."

The cook had a list of people's dietary requirements in the kitchen and knew who had specific dietary needs to maintain their health. Some people's food was pureed and some had fork-mashable meals. Some people were served a thick soup to help maintain their weight. The cook told us she had attended a "food texture" course. A visitor told us "Mum has pureed meals, there isn't any choice but she enjoys it."

Lunch on the second day of the inspection was a buffet, including quiche which we considered to be still frozen in parts. We also noticed that the blue plastic breakers used at lunchtime were dirty. We brought all of these observations to the attention of the home manager and the area director, who said they would address them. Following the inspection the manager informed us that the blue plastic beakers were not dirty but the surface had been damaged by the salt used in the dish washer. They had been replaced.

People were weighed monthly and care files included risk assessments in relation to nutrition. The home had a weighing hoist so that people who were not mobile could have their weight monitored. We saw that, when people were assessed as being at risk of malnutrition, referrals were made to a dietician or speech and language therapist as appropriate for advice. Care plans were put in place to address the risk and care staff kept detailed records of the person's food and fluid intake.

People had a spacious environment to live in with corridors that were wide and well-lit and pictorial signs available to guide them to regularly used areas such as the toilet and lounge. Most bedrooms had an open aspect making them light and bright. Bedroom doors were painted different colours to help people to identify their room, however there was scope for more pictorial representation to help people with orientation. There was a large clock in each lounge to help orientate people in time. On the top floor of the building there was a 'tea room' and a 'pub' which people could access with staff support. The manager told us a urinal was being fitted in one of the units that accommodated men only.

Good

Is the service caring?

Our findings

People who lived at the home were living with dementia and were not able to communicate their views to us verbally. The expert by experience spent two days observing the care provided to people and interactions with staff in the communal areas. We were also able to speak with 11 visiting relatives, some of whom told us they visited the home every day. The expert by experience commented "During this inspection I saw no resident in distress, or left alone or left wanting for a drink or snack or a kind word from the staff."

All the staff we saw had a caring and respectful attitude and treated people with kindness and compassion. Visitors told us "The staff make this home. My [relative] settled in well due to them. They are also so supportive of the family. It's always calm, I have never heard any shouting."; "They're very caring and patient. They don't put a show on."; "The care is absolutely brilliant. I can't fault them and I've been coming here for 12 months " and "The staff are marvellous, they genuinely seem to care. Everything is dealt with in a calm and professional way."

We looked at recent comments that had been made on the internet. People had written "The staff are so professional but this is tempered by them being able to give a hug and reassurance to the resident then sit and comfort them till they feel better. These acts of kindness made myself and my family feel reassured." and "The whole staff from cleaners to head carers are so helpful and welcoming towards the families."

We observed that many people were able to walk around the lounges and walk to their rooms unaided and had the mobility aids they needed to help them stay independent. We did not hear anyone being told to sit down.

All the visiting family members we spoke to thought their relatives were treated with dignity and respect. We saw that people were well dressed in clean clothes that had been carefully laundered. Some of the women wore jewellery and/or scarves. A hairdresser visited two days a week. Most people wore clean suitable footwear (slippers or comfortable indoor shoes). Aprons were used to protect people's clothing at mealtimes and we didn't see anyone with food on their clothing.

We observed that people's continence needs were met in a caring way with the minimum of fuss and in a dignified manner and they were returned promptly to the lounge. One person's care plan advised "[Person's name] does not like men, two female staff with personal care."

All the visitors we spoke to said they could visit at any time and were always made welcome by the staff. Some visitors told us they had Christmas dinner with their loved ones in the home. One relative said "If I phone them to say I'm taking her out, she's all dressed up when I get here." Relatives confirmed that they were kept informed and involved, for example "They tell us when they had to increase her pain relief."; "They consult me over her care plan." and "They do tell me what's going on and what they're doing for her."

The manager told us there was currently nobody living in the home with any specific cultural requirements. Records showed that people's religious views were considered and regular church services were held in the

home. Some people were taken to a nearby church by the activity coordinator.

We asked staff how they got satisfaction from their work and they told us "I love it when they remember my name." and "I love working with them, it's a good feeling." One member of staff described bringing their small child into the home to meet the people they supported and it was a mutually positive experience.

Care files included information about people's life stories, their family members, pets, friends, work history, skills and preference regarding music and television programmes. It provided very specific information about what was important to each individual. This helped staff to get to know people and provide support based on their preferences.

We saw that personal information about the people living at the home was kept securely in the office on each of the living units which protected the confidentiality of the information. A range of information leaflets was provided for people in the reception area and a copy of the home's 'service user guide' was given to the families of people new to the home. The manager had details of local advocacy services that could be contacted to support people who had no family or friends to represent them.

Good

Is the service responsive?

Our findings

The home had two activity coordinators and it was recognised that many of the people living there needed social stimulation in their daily lives. During the first day of our inspection there was an ice cream parlour function in the spacious reception area which was attended by many of the people who lived at the home and visitors. The next day there was an equally popular afternoon tea with fancy cakes and sandwiches.

Regular activities included manicures, film afternoons, armchair exercises, knitting, and doll therapy. One of the activity coordinators told us they bought 15 newspapers each morning for people at the home. The home had its own minibus and there were regular trips out to places including New Brighton, Llandudno, Llangollen and Ironbridge. Some people enjoyed a shopping trip to the nearby Asda supermarket. The activity coordinators also spent time with people on a one to one basis in their bedrooms.

On the top floor of the home there was a large room that was kitted out as a pub, where drinks could be served as appropriate and pub lunches took place five times a week. There was also a traditional style tea room.

All of the staff we spoke with had good knowledge of the people they supported and were able to answer our questions confidently. Care staff told us they had access to people's care files to find information about them. Information was also shared during shift handovers. One visitor told us they had been a registered nurse and was well aware of the care their relative required. They said "I've got no complaints about the care – and I'm fussy."
We observed that people were able to choose how and where they spent their time and staff respected their wishes, for example one person was still in bed at 11am and a member of staff explained "He'll get up when he wants to."

The care files we looked at provided person centred information regarding the care and support people required. People's preferences and life experiences were reflected throughout the plans for their care. We saw that all of the assessments and plans were reviewed monthly and updated as required.

The care staff we spoke with showed us the charts they kept to record the care and support they had given. For example, some people were not mobile and needed to be repositioned regularly to prevent pressure damage. All of these people had a pressure relieving mattress and one person had an armchair that could be tilted in various positions to relieve pressure. Care staff maintained records of repositioning. We also saw records of topical medication application, food and drink intake charts for people with weight loss, and records of checks carried out on movement sensor equipment and pressure mattress settings.

The home manager told us that people were able to stay at the home for end of life care. At the time of the inspection, one person was reaching the end of their life and staff were preparing for a syringe driver to be put into use to ensure that the person could be kept comfortable and pain-free. Some of the care plans we looked at had information about people's end of life wishes and funeral plans.

The home's complaints procedure was included in the information provided for people living at the home and their families. It was easy to understand and gave people details about who they could contact if they wished to make a comment or a complaint. It was also posted in the entrance area.

Visitors we spoke with said they had no complaints but if they did they wouldn't hesitate to speak to the manager. They would also be happy to raise a concern with any of the staff. Two people gave us examples of where they had raised an issue and it had been resolved quickly and to their satisfaction. The manager maintained a record of complaints received and the action taken. The records showed that complaints were investigated in line with the provider's policy and responded to appropriately.

We checked whether the service was following the Accessible Information Standard. The Standard was introduced on 31 July 2016 and states that all organisations that provide NHS or adult social care must make sure that people who have a disability, impairment or sensory loss get information that they can access and understand and any communication support that they need. We saw detailed information in people's care files regarding the support they needed with communication and use of aids such as glasses and hearing aids. We saw the use of some large and clearly written signage around the building to help orientate people.

Good

Is the service well-led?

Our findings

The home had a registered manager and three unit managers. All of the visitors we spoke to knew the manager by name and said they would feel able to approach her to discuss any issues. The home's administrator had an office in the entrance area of the home and we observed that she communicated in a helpful and friendly way with visitors arriving at the home.

We spoke with a new member of staff who said they loved their work and the other staff had been very helpful to them while they were settling into their new job. We saw that the manager tried to ensure the staff rotas accommodated family commitments whenever possible. The manager, the administrator, and several members of staff had worked at the home for a considerable number of years.

Records showed that regular staff meetings were held to gather staff member's views and share information. In addition to meetings for the whole staff team, we saw records of meetings for various groups of staff such as unit managers, nurses and nursing assistants, and activities.

Relatives' meetings were held three monthly, the most recent being on 26 July 2018. Relatives were also able to express their views through an annual satisfaction survey. The 2018 survey has just been returned to the manager for comment. An electronic touch screen was available in the reception area for people to provide feedback regarding the service at any time.

The manager told us about, and showed us records of, the various ways she checked the quality of the service. These included a twice daily walk round, daily 'flash' meetings for heads of department and night visits. There was an annual programme of quality audits which included a three monthly health and safety inspection, infection control audits of each unit, catering audits, daily cleaning schedules and spot checks, medication and care plan audits. A monthly accident analysis clearly recorded actions that had been taken following each accident or incident.

Each of the unit managers provided a monthly 'key clinical indicators' return to the manager covering areas relating to the people they supported including their weight, any pressure sores or infections, and falls. The manager then submitted this information to head office and a report and action plan was generated and discussed with the unit managers. A monthly home improvement plan was written.

There was also a detailed bi-monthly audit of the home by area director, the most recent being on 24 and 25 July 2018. Areas requiring improvement were identified and actions written for the manager to follow up. We observed a positive and supportive relationship between the home manager and the area director.

The registered provider is required by law to notify the CQC of specific events that occur within the service. Prior to the inspection we looked at notifications that had been submitted by the manager and found that this was being done.

The registered provider is required by law to display their current CQC rating in a prominent place within the

service. During the inspection we observed that a summary of the home's last CQC inspection report was available for people to look at and it was clearly shown on the organisation's website.