Wessex Care Limited

Castle View Nursing Home

Inspection report

8 Old Castle Road
Salisbury
Wiltshire
SP1 3SF

Tel: 01722328315
Website: www.wessexcare.com

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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

This inspection took place on 25 June 2018 and was unannounced.

Castle View Nursing Home can accommodate up to 25 people. People in care homes receive accommodation and nursing or personal care as a 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 provides accommodation over three floors which were accessed by a lift. There was an enclosed garden and a small parking area. The service had eight rooms that had been designated for 'intermediate care'. People could access 'intermediate care' from hospital to receive rehabilitation for a short period of time. At the time of our inspection 17 people were living at the service and six people were temporarily staying on 'intermediate care'.

At our last inspection we rated the service good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

At this inspection we found the service remained good.

There was a registered manager in post. 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 continued to receive safe care. Risks had been identified, assessed and there were safety measures in place to keep people safe. There were systems in place to keep people safe from abuse or harm.

There were sufficient staff on duty to support people safely. The service had completed the necessary recruitment checks to make sure suitable staff were employed.

People continued to be effectively supported by a team of staff who were trained and well supported to meet their needs. Medicines were managed safely. Staff had been assessed as competent to administer medicines.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Where needed and appropriate the service made referrals to external healthcare professionals in a timely way. People had individual care plans that had been personalised.

People had sufficient food and drink and could choose where to eat and what to eat and drink.

The service was clean with no unpleasant odours. The environment was well maintained and equipment was serviced regularly when appropriate. Staff used personal protective equipment when required.

Complaints were managed by the provider and lessons were learned.

Staff were able to attend team meetings and told us the organisation were supportive and provided opportunities for development.

People and their relatives were encouraged to give feedback formally and informally.

Further information is in the detailed findings below.

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 remained safe.	Good
Is the service effective? The service remained effective.	Good
Is the service caring? The service remained caring.	Good
Is the service responsive? The service remained responsive.	Good
Is the service well-led? The service remained well-led.	Good

Castle View 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.

This comprehensive inspection took place on 25 June 2018 and was unannounced.

The inspection was carried out by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information we held about the service. This included notifications the service had sent us. Notifications are sent to us by providers to inform us about events that occur at the home such as deaths, accidents/incidents and safeguarding alerts. We asked the provider to complete a Provider information return (PIR). This is a form that asks the provider to give us some key information about the service, what the service does well and any improvements they plan to make.

During the inspection, we spoke to nine people, two relatives, two visiting healthcare professionals, operations director, the registered manager, head of care and five members of staff. We looked at a range of records during our inspection. This included six care plans, three staff files, training records, meeting minutes and other records relating to the management of the service. Following our inspection, we contacted four healthcare professionals that have been working with the service and spoke to one member of staff on the telephone. We also asked the provider to submit further pieces of evidence. We included this information when reaching judgements about the service provided.

Good

Is the service safe?

Our findings

People told us they felt safe living at Castle View Nursing Home. Comments included, "I feel safe here, the carers look after me", "I had several falls at home and I didn't feel confident but I feel safe here", "The carers make sure I'm safe" and "The carers take good care of me."

Systems were in place to safeguard people from the risk of abuse. Staff we spoke with understood their responsibilities to keep people safe from harm. They were aware of the different types of abuse and what indicators might cause concern. Staff were clear about how to report any concerns and were confident the management would act appropriately.

Risks to people's safety were assessed and managed to reduce identified risks. There were risk assessments in people's care plans that covered a range of areas such a moving and handling, falls and pressure area development. Where people had bed rails the service had put risk assessments and additional safety measures in place such as bed rail inspections. Bed rails can cause entrapment if not used safely.

People's medicines were managed safely. Registered nurses who had undertaken medicine management training were responsible for the administration of medicines in the home. Records demonstrated that staff were assessed three times before they were confirmed as competent to administer medicines. People's medicines administration records (MAR) were completed in full with no gaps in recording. We observed a nurse administering medicines and their practice was safe. They demonstrated an understanding of people's individual needs and preferences around how they wanted to take their medicines and when.

There were suitable numbers of staff to meet people's needs and help them to stay safe. Staffing levels were based on people's dependency. The provider used a dependency tool to help them calculate the staff needed. The service reviewed people's dependency so that support could be given when people needed it. People and their relatives told us they thought there was enough staff to meet their needs. One healthcare professional told us, "There are always staff around, I can find someone if I need to."

There were appropriate recruitment checks in place to make sure suitable staff were employed. The provider had completed a check with the disclosure and barring service (DBS). The DBS carry out a criminal record and barring check on people who have made an application to work with vulnerable groups. This helps employers to make safer recruiting decisions and helps prevent unsuitable staff from working with people.

Accidents and incidents were recorded and monitored to identify any patterns or trends. This helped the management to reduce the possibility of reoccurrence. Staff could attend a handover where information was shared about people's needs.

We observed the home was clean throughout and there were no unpleasant odours. Staff had access to personal protective equipment such as gloves and aprons. We observed they used it appropriately and when required. The premises were well maintained and in good repair throughout. The provider employed a

team of maintenance workers who can visit at any time to respond to requests for maintenance.

Checks were in place to make sure the environment and equipment in the service was safe. These included testing fire alarms, personal emergency evacuation plans, water temperature checks and regular servicing of equipment. The provider used an external health and safety management firm to support them with compliance.

Good

Is the service effective?

Our findings

People and their relatives told us care was delivered to meet people's needs. Comments included, "They tell me if there are any issues, it gives me confidence [relative] is getting the best care" and "I am very happy, I get the care that I need." One healthcare professional told us, "There is excellent communication here, they all work as a team to meet people's needs."

People's needs were assessed and documented in their care plans. Prior to people moving into the service the head of care or registered manager completed a pre-admission assessment. This process made sure that the service assessed people's needs and identified if they could be met appropriately by staff. A healthcare professional told us they had confidence that the staff team knew what people's needs were.

The provider used 'This is me' booklets to record needs such as mobility, eating and drinking and communication. These booklets are designed to be shared with other services should the person transfer, for example, if they went to hospital. This supported other professionals to have some key information.

There were nurses available on every shift to support people with their nursing and health needs. Staff we spoke with knew signs of ill health and told us they would report concerns to the nurses on duty. Where appropriate people had access to additional healthcare professionals such as GP's, physiotherapists and speech and language therapists. People who stayed on 'intermediate care' were supported by an occupational therapist and physiotherapist most days. This meant they could have regular rehabilitation to maximise their independence.

The provider had commenced a scheme to improve the timely care and support people received. The local specialist tissue viability nurse was supporting nurses working for the provider to become 'link tissue viability nurses'. This meant the nurses were attending additional training to improve their skills and knowledge in this area of healthcare. Due to the lack of resources in the local area this scheme would mean that people would have better access to a tissue viability specialist.

People told us they enjoyed the food on offer. The meal time we observed was not hurried and people had a choice of where to eat their meal. Comments from people about the food included, "The food is always good", "The food is nice and I always eat it", "I just ask for something else if I don't like what is on the board." One person told us, "I like the food but the portions are big, so I asked for a pudding only at lunchtime and then eat a good tea, they don't mind and know what I like."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We found the service was working within the principles of the MCA.

People's care plans all contained a statement which outlined that care plans had been devised with the

principles of the MCA in mind. Staff we spoke with were aware of the MCA and how it applied to their work. People can only be deprived of their liberty so that they receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We found there were people with a DoLS authorisation in place. The service had also made applications which were waiting for authorisation.

Staff had a robust induction which covered a range of areas. Training was available to all staff and records demonstrated staff had been trained. Supervisions were completed monthly for all staff. Comprehensive records were kept which recorded the discussion. Staff told us they felt well supported by the management. One member of staff told us, "I have supervision every month, there is lots of support." They told us they could ask for any training they wanted to help them gain new skills and knowledge.

In the PIR (Provider information return) the provider told us 'Castle View has been completely re-decorated, the main lounge has been completely re-furbished and the residents and staff helped to pick out the décor. The staff have spent numerous hours assisting the residents to personalise their bedrooms and other areas of the building to great effect.' The environment was homely and bright. People had access to communal areas and a secure garden. There was garden furniture available outside so people could enjoy the warmer weather.

Good

Is the service caring?

Our findings

People and their relatives told us the staff were caring. Comments included, "The carers are very nice, very caring", "I can talk to them when I need to", "They [staff] can't do enough for my husband" and "The carers are lovely." One healthcare professional told us they thought the staff were "amazing".

Relatives told us they could visit at any time. One relative said "I can come anytime night or day." Staff confirmed that visitors were welcome at any time. We observed visitors were offered refreshments and could have a meal with their relative if they wished. One relative told us they enjoyed visiting so they could support their relative to eat. They said, "The carers are happy for me to do it."

Staff enjoyed working at the service and found their roles rewarding. Comments included "I love working with older people, I find it really rewarding", "I enjoy my job so much" and "I love working here, I love the contact with people and being able to see people take part and enjoy activities."

We observed many positive social interactions between people and staff. It was evident staff knew the people they were supporting. People looked comfortable around staff and did not hesitate to ask for help and assistance. Staff responded with kindness and respect. For example, one person during meal time was struggling to pick up their cutlery. A member of staff observed this and offered discreet support. They offered verbal encouragement and made sure the person had the aids they needed. We observed the member of staff keeping a close observation of this person during the meal time making sure they were fine throughout.

Staff knocked on people's doors and waited to be invited in and closed doors when supporting people in rooms or bathrooms. This supported people's privacy. Staff gave us examples of how they maintained dignity. They told us "we close curtains when we are doing personal care", "make sure only the staff that are needed are in the room" and "I always ask people can I help them, I ask for consent."

We observed and staff told us different methods they used to communicate with people. One member of staff talked to us about how they always sat level with the person to communicate. We saw that they did this when communicating with people. One person became anxious and started repeatedly asking for help. We observed the staff member responded with patience and an understanding of the person. They sat with them until their anxiety had reduced and held their hand. They talked to them using simple sentences and listened to their anxieties. This person responded with smiles, they clearly appreciated the support.

People were encouraged to express their views and be actively involved in making decisions. People had been given a choice of whether they wanted a male or female care worker to support them with their personal care. Decisions were recorded in people's care plans. Care plans were stored in people's rooms so they had access at any time. There were regular 'resident meetings' where people could discuss concerns, wishes and activities.

Good

Is the service responsive?

Our findings

People had their own personalised care plan that was reviewed regularly. The care plan covered a range of needs such a mobility, eating and drinking, sleep and rest and personal hygiene. Care plans had information for staff on people's backgrounds and there was an individualised plan for social needs and activities.

Health needs were recorded and a plan in place to make sure people had personalised support. For example, one person had a catheter. Their care plan recorded the care this required and the dates it had been changed. Where people required wound care, there were plans in place to promote healing and record the progress of the healing process. Nursing staff evaluated people's care and treatment to make sure care was meeting people's needs.

The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The service highlighted people's communication needs in their care plans. Preferred methods of communicating were recorded and methods for staff to use. The operations director told us they could give people information in various formats to suit people's needs. They produced information in large print, in simplified formats and pictorial guides.

Where people struggled to communicate relatives had been involved in care planning. For example, one person who had difficulties communicating due to a stroke had wanted their relative to be involved. We saw they had written goals in the care plan with help from their relative. These were person-centred and recorded how they wanted to be communicated with. Staff told us about how they used audio books to support people with a visual impairment to continue to read.

There was a dedicated activities worker who worked with the staff team to support people's well-being and social needs. They had been involved in reviews of care needs and contributed to care planning. A monthly activity plan was produced and shared with people. Copies were available in people's rooms and on notice boards. The activity worker told us they could adapt this if needed and make it pictorial or larger print if needed.

Activities were person-centred and based on people's needs, wishes and preferences. People told us they enjoyed the activities on offer. One person said, "I like to do crosswords and the carers make sure I've got books to do them." Another person told us they enjoyed spending their time in their room. They had a very large TV and told us "I brought it in with me; it's a smart TV so needs Wi-Fi to work. I reckon the manager has put a signal booster in for me so I get a good signal."

People who were staying on 'intermediate care' could also participate in activities. They had daily exercises prepared for them by healthcare professionals. The aim was for them to develop their independence to be able to return to their home. One person told us "I get encouraged to walk every day. They [professionals] gave me a walking aid to help me as I am not as confident as I was before I came in here."

Complaints were managed by the provider. The provider recorded all complaints received, investigated concerns and responded to the complainant within an identified timescale. People told us they could raise any concern if they wanted to. One relative said, "I have no complaints, if I have any issues I know I can say and something will get done." There was a suggestions box in the foyer where people and visitors could leave feedback, suggestions or comments.

End of life care had been provided. People had the opportunity to record their wishes in their care plans. The service had worked with local healthcare professionals to obtain the necessary medicines and equipment to make sure people were comfortable at the end of their lives. Staff received end of life care training and nurses were being upskilled in this area of healthcare. The service had received many compliments about the end of life care provided. One relative had written, 'The care you gave [relative] was truly five star and the best, it was comforting to know that the last days were with the most caring, wonderful people. The love, compassion and dignity [relative] was treated with was absolutely wonderful'.

Good

Is the service well-led?

Our findings

The service continued to be well-led. People told us they liked living at Castle View Nursing Home. Comments included, "I like it here, the carers are good and very helpful" and "I like it here, I am happy they [staff] care about what we think." A relative told us "I chose this home after looking at seven other care homes. This is the best. I am fussy, I can't fault this place." A member of staff told us "I like it here; the variety of work is good and I love to help the residents and see the results."

There was a registered manager in post. 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 registered manager was supported by a head of care in the day to day management of the service. People, relatives, staff and healthcare professionals told us the management was approachable, open and available. Management worked closely with external professionals. There was a healthcare professionals meeting at the service every week. A healthcare professional told us the head of care was "responsive" and "doesn't hesitate to contact us where needed".

Staff told us there was a positive culture at the service. They felt able to share ideas and felt they were listened to. There was a clear staffing structure within the service which helped staff to understand their responsibilities. Staff had regular team meetings where information and learning could be shared. Staff we spoke with felt there was good team communication. One member of staff told us "We are a close-knit team, we all help each other." The provider considered themselves to be "family friendly". They offered staff the opportunity to work hours around family life.

The operations director told us they had good staff retention which enabled them to provide consistency of care. In the PIR the provider told us 'We are constantly thinking outside of the box to improve and secure staff retention i.e. child care vouchers, discounts at local gyms, free exercise classes and flexible working hours'. Staff were offered different training opportunities and expected to complete a national diploma in health and social care. There were opportunities for staff to develop within the organisation. The provider managed five residential services in the local area and a small community service. Staff could work in any service if they wanted to.

The service was continuously learning to improve and develop. The provider had plans to introduce new systems which would enhance care delivery. One of these systems was an electronic medicines system. The operations director told us they were always keen and willing to be part of piloting new systems and processes.

People and their relatives were formally asked for their feedback about the service quarterly. Results from the most recent surveys demonstrated that overall the service was providing a service that people were satisfied with. The provider had analysed the results and taken action where people or their relatives had

given ideas for improvement. For example, one relative asked the service to provide more drinks for their family member. The service informed staff of this request and put in place fluid monitoring forms to monitor intake. One person had raised that their internet was not consistent. The provider installed a booster for this person so their internet was strengthened.

The service had links with the local community. The library service visited monthly to enable people to choose their own books if they were not able to or did not want to use the main library. One person told us "I love reading, the home makes sure I've got books." There was a pub nearby which people could access if they wished for a drink, meal or event such as a quiz. There were two volunteers who had been provided through a local care home volunteer service. Volunteers visited the service to be-friend people and work one-to-one with people who may be at risk of isolation.

The provider had effective quality monitoring systems which were comprehensive. There were monthly audits for key areas such as falls and pressure ulcers. This enabled the service to monitor falls and incidents where a person developed a pressure ulcer. The head of care told us this gave them an overview of people's care needs so that action could be taken to improve outcomes. For example, one person had been identified through the falls audits of experiencing a number of falls in one month. The service tested their urine and found they had a urine infection. This meant the person could have treatment which resulted in their falls reducing to none the following month.