Care Quality Commission

Sai Care Limited

Safe Harbour Dementia Care Home

Inspection report

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Date of inspection visit:
07 February 2018
08 February 2018

Date of publication:
13 January 2020

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 7 and 8 February 2018 and was unannounced on the first day. At our last inspection we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had not always effectively assessed and monitored the safety, risks and quality of the service provided. During this inspection we found that improvements had been made to meet this requirement.

Safe Harbour 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 accommodates up to 47 people who are living with dementia.

The home is required to have a registered manager and a registered manager was in post at the time of the inspection. 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 living at the home were protected from abuse because staff knew how to report any concerns they had and had access to the relevant contact details. Potential safeguarding incidents had been reported to the local authority and the Care Quality Commission as required. Training records showed that staff had received training about safeguarding.

During our inspection we found that there were enough staff and the use of Agency staff had reduced. Staff had time to chat with people and reassure them. New staff were recruited in a safe way that ensured they were suitable to work with people at risk of neglect or abuse.

Enough domestic staff were employed and on duty each day. The home was clean and fresh smelling. We found good records of repairs, regular tests, calibration and servicing of equipment and services at the home to ensure they were safe. People's medication was managed safely.
Where people were identified as being at risk of harm, risk assessments were in place and action had been taken to mitigate the risks.

The home was compliant with the Mental Capacity Act 2005. Where people required the protection of a Deprivation of Liberty Safeguard, this had been applied for and records in the home showed who had a DoLS in place and who had had a DoLS applied for.

People told us they enjoyed their meals and arrangements were in place to support people who were at risk of malnutrition or dehydration.

Staff told us that they had access to a variety of training and were currently undertaking First Aid training. The training records we looked at during the inspection were incomplete, but following the inspection the manager sent us further information to show that the staff team were up to date with important training to ensure they knew how to work safely.

The care staff were based in the lounge areas to support people as and when required. We saw that throughout the day staff sat with people and talked to them. People's friends and relatives were free to visit at any time and some visitors told us they came every day.

People's care files contained a series of assessments of the person's care and support needs. Where an assessment indicated the person required care then a care plan was in place to guide staff. These had been reviewed on a monthly basis and were generally up to date.

The home employed an activities co-ordinator and there was a schedule of social activities on noticeboards throughout the home. During our inspection we saw people engaging in and enjoying group activities.

The home's complaints procedure displayed in the home needed to be made clearer and more concise.

The manager held monthly relatives meetings and regular staff meetings.

The manager undertook various audits and checks to monitor and improve the standard of care provided at the home. These included monitoring of medication, care files, accidents, hygiene, and health and safety. There were reports of periodic night time visits to the home by the manager and the deputy manager and reports of mealtime observations.

Since our last inspection, CQC has received a number of complaints about the home made by former members of staff. The issues they raised have been fully investigated by an external company and none have been upheld. During our inspection we found no evidence to support the complaints.

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 managed safely.

The premises were clean and well maintained.

People who used the service were protected from abuse.

There were enough staff to provide care and support for people and new staff had been recruited safely.

Is the service effective?

Good

The service was effective.

A comprehensive programme of staff training was in place.

The home complied with the requirements of the Mental Capacity Act 2005.

People received enough to eat and drink.

Is the service caring?

Good

The service was caring.

People who lived at the home, and their relatives, were very happy with the staff team and described them as kind and caring.

We observed positive and respectful interactions between staff and the people who used the service and their relatives.

Confidentiality of people's personal information was maintained.

Is the service responsive?

Good

The service was responsive.

People were able to exercise choices in daily living.

Care plans described people's care and support needs in a person-centred style.

A variety of stimulating social activities was provided.

People told us they felt able to raise any concerns they had.

Is the service well-led?

Good

The service was well led.

The home had a manager who was registered with CQC.

Staff told us they felt supported by the management and relatives considered the manager and deputy manager were approachable.

A programme of quality audits was implemented.

CareQuality Commission

Safe Harbour Dementia Care 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 checked 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 7 and 8 February 2018 and was unannounced on the first day. On the first day, the inspection was carried out by an adult social care inspector 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. On the second day, the inspection was carried out by two adult social care inspectors.

Before the inspection we looked at any information CQC had received about Safe Harbour since our last inspection. The manager had completed a 'Provider Information Return'. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with six people who lived at the home, seven relatives, nine members of staff, and one of the providers. We also had a meeting with 13 staff. We observed care and support people received in communal areas including one to one care provided to two people. We looked at the care records of five people who used the service. We looked at staff records, health and safety records and management records, and the management of people's medication.

Good

Is the service safe?

Our findings

We spoke with people who lived at the home and relatives who were visiting them.

Staff knew how to report any concerns they had and said they had access to the relevant contact details. Polices were in place to guide staff on how to report potential safeguarding concerns and how to whistleblow. A whistleblowing policy protects people who report a workplace concern they believe is in the public interest. Staff were aware of how to report potential abuse and how to report any whistleblowing concerns they may have. A senior member of staff explained that they followed guidance from the local authority on what to report and records confirmed that potential safeguarding incidents had been reported to the local authority and the Care Quality Commission as required. Training records showed that staff had received training about safeguarding.

During our inspection we found that there were enough staff and rotas we looked at confirmed that these numbers were maintained. The manager used a monthly dependency tool to decide the correct staffing levels. The manager had recently recruited two registered nurses to work on day duty and the deputy manager was also a registered nurse. Night duties were covered by nurses supplied by an Agency. The rotas we looked at showed that the same three Agency nurses worked regularly at the home. This meant that they had the opportunity to get to know the people living at the home and provide continuity of care. A number of new care staff had been recruited which meant that the use of Agency care staff had reduced.

Two of the people living at the home were provided with one to one care by staff. We saw that this was well organised with members of staff identified to support the person for periods of two hours. Staff told us that there were always sufficient staff available to provide the one to one care in addition to those required to support other people living at the home. They also told us that there were always enough staff on shift to support people safely and well. The interactions we saw between staff and people living at the home were positive. Staff had time to chat with people and reassure them.

Records showed that new staff were generally recruited in a safe way that ensured they were suitable to work with people who may be at risk of neglect or abuse. We pointed out to the manager some areas where improvements could be made. For example: the application form asked candidates for their date of birth, which is not permitted by employment law; the application form did not ask candidates their reason for leaving their previous employment; interview notes were not always legible. Registration number checks were carried out for registered nurses including Agency nurses.

Enough domestic staff were employed and on duty each day. The home was clean and fresh smelling. Gloves, aprons, wipes and cleaning gel were available for staff to use. Contracts were in place for the safe disposal of waste. The home scored 94% on the most recent infection control audit by NHS staff and the kitchen had a five star food hygiene rating.

The staff member responsible for maintenance had worked at the home for many years and kept detailed records relating to the safety of the building and equipment. We found good records of repairs, regular tests,

calibration and servicing of equipment and services at the home. The maintenance person did a daily walk around the building and any risks identified were addressed. A monthly health and safety audit of each person's room was completed. There was a fire risk assessment, a weekly test of the fire alarm and periodic fire drills, each producing a report. As part of their induction new staff were trained in fire safety.

Personal emergency evacuation plans had been written for each of the people living at the home. The date of the last review of these was 29/12/17 so we were not sure if they were up to date. We also noticed that the emergency folder did not contain telephone numbers that may be needed in an emergency situation, for example names and contact numbers for the two places that had been designated as places of safety that people could be evacuated to if necessary.

Medication was stored in two locked medication rooms, one on each floor. The nurse or senior carer administering medication wore a red tabard asking not to be disturbed during the medication round. There was a medication administration record sheet for each person which contained a photograph of them and a record of any allergies. There were records of any 'as required' medication given and guidelines for staff on when these should be used. The registered manager completed a weekly audit of medication by checking people's medication on a rotating basis and auditing 'as required' medication.

Where people were identified as being at risk of harm, risk assessments were in place and action had been taken to mitigate the risks. We saw that accident records were completed in full and were summarised monthly and action taken as needed. When people were identified as being at high risk of falls, timely referrals were made to the falls prevention team. We tracked an accident one person had had and saw that this had been managed well to deal with the initial incident and prevent or minimise future occurrences. As well as seeking medical attention initially, measures had been put in place to support the person to prevent a future fall or minimise the harm from a future fall. The incident had been reported to the appropriate authorities and, as the unforeseen accident had been caused by a piece of equipment, steps had been taken to make this safer for people to use. Some people had crash mats and sensors in their room which alerted staff if they walked unaided. Some people had profiling beds which could be positioned very low to the floor if there was a risk of a person falling out of bed.

We observed two members of staff supporting a person to be moved from their chair to a wheelchair via a hoist. The person was clearly nervous about the process and staff provided the support safely and as efficiently as possible whilst providing the person with reassurance.

Good

Is the service effective?

Our findings

People told us that staff sought their consent before providing care and support to them.

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

Where people required the protection of a DoLS this had been applied for and records in the home showed who had a DoLS in place and who had had a DoLS applied for. Assessments had been carried out to determine whether people had the capacity to understand and make decisions relating to their care and support. When the assessment showed the person was unable to make the decision, a best interest decision had been recorded to show why others had reached that decision on the person's behalf. These had been used for various decisions for individuals including whether they needed covert (hidden) medication and whether they needed support with their personal care.

We observed lunch being served on the ground floor. Most people were supported to have their meal in the dining room with only two people remaining in the lounge for lunch by choice.

Jugs of juice were available in the lounge areas all day. We saw people being given extra drinks as they required. Tea and cake was served in the afternoon. We looked at records for one person that showed they had lost weight at one point. Staff had liaised with their GP and dietician and had weighed the person regularly to monitor this. Records showed that with staff support the person had gained weight. We spoke with a member of the catering staff who had good knowledge of people's individual dietary needs. Staff told us that the cook meets new people to the home and also visits the units after every meal to check people have enjoyed their meal.

Staff told us that they had access to a variety of training and were currently undertaking First Aid training. Staff said they have support to do a national vocational qualification if they wished. One of the senior staff told us they had NVQ level 4 and were working towards level 5. Some staff had undertaken House of Memories training at Liverpool museum and a number of staff were "dementia friends". A dementia friend has learned a little bit more about what it's like to live with dementia and then turns that understanding into action.

The nurse we spoke with was new to the home and explained that she was qualified as a mental health nurse. She told us that the deputy manager was supporting her with training to meet her role within the home, including end of life care, and wound care.

The training records we looked at during the inspection were incomplete, but following the inspection the manager sent us further information to show that the staff team were up to date with important training to ensure they knew how to work safely.

Staff said they had regular supervision and that monthly staff meetings took place as well as a meeting each morning. Supervision and appraisal records we looked at during the inspection were incomplete, but following the inspection the manager sent us further information to show that members of the staff team had regular individual supervision meetings and an annual appraisal.

Care records we looked at showed that people had had access to a range of health care professionals including GPs, district nurses, dietician, and community mental health nurse.

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Good

Is the service caring?

Our findings

We observed staff to be respectful in their dealings with the people who lived at the home and their families. Personal care was provided discretely which protected people's dignity. Staff told us that they were encouraged to interact with people whatever their role. We saw this during our inspection, for example we saw that domestic staff took time to sit with people and have a little chat. The care staff were based in the lounge areas to support people as and when required. We saw that throughout the day staff sat with people and talked to them. On one occasion, a person who lived at the home became anxious and distressed and a member of staff spontaneously gave the person a hug and was able to comfort them.

Staff providing one to one care to people did so in a calm, patient manner. They were aware of the risks to people and were vigilant in preventing these whilst supporting the person to walk around if they wished. They spent the time talking with and interacting with the person as well as supporting them to stay as safe as possible. Personal biographic Information in people's care files helped staff to understand them as individuals.

People appeared comfortable in their surroundings and there was a relaxed atmosphere.

People's friends and relatives were free to visit at any time and some visitors told us they came every day. There was a noticeboard with photographs and names of the staff team to help people identify individual members of staff.

Pop music was playing through speakers in the corridors and we discussed with the manager that this may not be to everyone's taste.

We also discussed with the manager that some of the language used both verbally and in care documents was not always sensitive, for example people being described as "doubly incontinent", and the ground floor living unit described as "EMI residential".

People's records were kept in a locked office within a filing cabinet. In the nurses' office we saw that a large whiteboard contained information about people living there including who had a DoLS in place and who had a do not resuscitate order in place. We discussed this with a senior member of staff who told us that occasionally visitors did enter this room. As this means they may see the information on the whiteboard the senior member of staff said they would in future ensure visitors did not use this room.

Good

Is the service responsive?

Our findings

Relatives we spoke with said they were always involved in their loved one's care and communication was good. Staff knew people well and were able to explain people's preferences and choices.

People's care files contained a series of assessments of the person's care and support needs. This includes their nutrition, personal care needs, mobility, risk of falls and skin integrity. Where an assessment indicated the person required care then a care plan was in place to guide staff. These had been reviewed on a monthly basis and were generally up to date. We did see one person's care plan that listed equipment to prevent the person falling. We saw this was no longer used or had been replaced. Three members of staff we asked were aware of these changes and could explain why they had been made. We asked a senior member of staff to make sure the person's plan was updated to reflect this.

Each care file had a photograph of the person and a profile containing important information about them, for example contact details of family members and other people involved in their care, their preferred language, faith, allergies, current medication and medical history and how they communicated. Care plans also contained details of what was important to people. Care files were accessible for the care staff to read and refer to. A senior carer told us they were working towards making care plans more person-centred.

The home employed an activities co-ordinator and there was a schedule of social activities on noticeboards throughout the home. During our inspection we saw people engaging in group activities. On the first day there was a quiz which people joined in and resulted in singing and laughing. On the second day a singer performed and people joined in, dancing and singing along. The home had an enclosed garden with a summer house and with chickens and rabbits. We saw one of the people who lived at the home clearly enjoying being out in the garden and helping to care for the animals despite the bad weather. People also had some trips out including to a tea dance once a month.

We asked people if they felt able to make a complaint and how their complaints had been dealt with.

A copy of the home's complaints policy and procedure was displayed in the entrance area. This ran to 11 pages and did not give clear information to people, for example it did not have the names and contact details for the manager and the provider. We advised the manager that this needed to be made clearer and more concise and he agreed that this would be done. The manager kept a record of complaints he had received along with a record of outcomes.

Good

Is the service well-led?

Our findings

The home had a registered manager, and a deputy manager. The manager's office was at the far end of the building from the front door entrance and there was no signposting to help people find it. It was also necessary to walk through the ground floor dining room to reach the manager's office and this was intrusive when people were having their meal.

Staff said they felt listened to and supported. They said that senior staff listened to their point of view regarding people's care. One member of staff commented "We get on well, we are like a family, we care about the residents." All members of staff saw it as part of their role to support the people living at Safe Harbour, for example domestic staff told us that they took time to get to know people and talk with them and we saw this in practice. Staff were thoughtful about their role and the support they provided to people. They had some good ideas for further improving the support people received. We discussed this with the provider who was, and had been, open to ideas from staff for future improvements including decoration and refurbishment.

The manager held monthly relatives' meetings. The minutes from the last meeting were displayed on the relatives' notice-board along with the date of the next meeting. We also saw records of regular staff meetings. Each weekday the manager held a head of departments meeting. There were satisfaction questionnaires available in a box near the front door and the manager told us he had just sent out questionnaires to people's families but none had been returned yet.

The manager undertook various audits and checks to monitor and improve the standard of care provided at the home. These included monitoring of medication, care files, accidents, hygiene, and health and safety. There were reports of periodic night time visits to the home by the manager and the deputy manager and reports of mealtime observations.

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 this had been done.

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

Since our last inspection, CQC has received a number of complaints about the home made by former members of staff. The issues they raised have been fully investigated by an external company and none have been upheld. During our inspection we found no evidence to support the complaints.