

N. Notaro Homes Limited

Serenita

Inspection report

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Ratings

Overall rating for this service	Good ●
Is the service safe?	Good ●
Is the service effective?	Good ●
Is the service caring?	Good ●
Is the service responsive?	Good ●
Is the service well-led?	Good ●

Summary of findings

Overall summary

Serenita is a residential care home that offers housing and personal support for up to 34 adults who have a range of needs including mental health problems such as Korsakoff's syndrome and the effects of alcohol related brain damage. The support at Serenita is based on a three step enablement programme supporting people to return to the community.

The service has a large open plan lounge, dining room and games area, an accessible garden and bedrooms all of which are en-suite. At the time of our inspection 28 people were using the service. At our last inspection we rated the service good. At this inspection we found the service remained good. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

Systems were in place to safeguard people from abuse and staff knew the procedure and guidance to follow if something went wrong. Risks relating to people's care were identified and staff knew how to manage these risks to help keep people safe but still encourage people's independence. Staff spoke to people about the risks they faced to help people understand how to keep safe.

People's medicines were managed safely by staff. There was enough staff to care for people and they received adequate training, induction and supervision to support them to do their jobs. The recruitment process ensured staff were suitable to work with people.

People's needs and preferences were assessed by the service before they began receiving care. People had a choice of food and helped plan their weekly menu. Staff encouraged people to make healthy choices when they needed to. Staff promoted the healthcare needs of people and worked well with healthcare professionals, they took on board recommendations to help make sure individual health needs were met.

Specialist dietary needs such as those associated with diabetes were provided for. 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.

People were encouraged to be as independent as they could be. Staff treated people with dignity and respect. People were supported to be involved in hobbies and activities that interested them. This included access to the community and involvement with clubs and outside social events when people wanted to.

People's care plans were sufficiently detailed to inform staff about people's needs and to guide staff in caring for them. The service had a complaints procedure which addressed any complaints within the agreed timescale. Systems were in place to make sure managers and staff learnt from events such as accidents, incidents and complaints. This reduced the risk to people and helped the service continually improve. The service had a range of audits in place to assess, monitor and drive improvement.

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 remains Good

Is the service effective?

Good ●

The service remains Good

Is the service caring?

Good ●

The service remains Good

Is the service responsive?

Good ●

The service remains Good

Is the service well-led?

Good ●

The service remains Good

Serenita

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 11 October 2018 and was unannounced, it was a comprehensive inspection. The inspection team consisted of 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, the provider completed a Provider Information Return (PIR). 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.

We reviewed information we held about the service. This included the action plan which the provider had sent to us following the last inspection, feedback received about the service and statutory notifications that the provider had sent us. A statutory notification provides information about important events which the provider is required to send us by law.

During the inspection, we spoke with 10 people using the service. We made direct observations at meal times. We spoke with five staff in total. They included two care staff, the chef, the deputy manager and the manager.

We looked at the care records for six people, the recruitment records for eight care staff and staff training information. We looked at a range of documents including meeting minutes, complaints, audits and records related to how the provider monitored the quality of service. Prior to the inspection, we spoke with the local authority contracts and compliance officer and were given a copy of their report.

Is the service safe?

Our findings

This service remained safe.

People told us they felt safe. People's comments included; "Yes (I feel safe), because they have the cameras to stop people getting in". Another person told us, "Yes, because the staff are always around". Another person said, "Knowing that there are staff around. I can discuss anything with the staff". Staff told us they would report concerns immediately to their line manager or the senior person on duty. Staff were also aware they could report externally if needed. Comments included; "I'd raise the alarm and go to the manager", "I would report my concerns to the manager I'd also call the local authority safeguarding team and the CQC (Care Quality Commission)" and "I'd report concerns to the manager and CQC". The service had systems in place to investigate and report concerns to the appropriate authorities. One staff stated "This is a very, very safe place for people. It's a dry house and they are well looked after."

Risks to people were well managed. Where people were identified as being at risk, assessments were in place and action taken to manage the risks.

Staff had been trained in infection control procedures and were provided with personal protective equipment (PPE). An up to date infection control policy was in place which provided staff with information relating to infection control. This included; PPE (personal protective equipment), hand washing, safe disposal of sharps and information on infectious diseases. We spoke with staff about infection control. Their comments included; "We have loads of PPE" and "I get support with cleaning materials, colour coded equipment, gloves and aprons. We are never short".

There were sufficient staff to meet people's needs. Staff were not rushed in their duties and had time to sit and chat with people. One person said, "There seems to be just enough staff". When we spoke with staff their views on staffing levels their responses varied. For example, three staff felt there were enough staff available to meet people's needs. However one member of staff felt that there were times when there were not enough support workers on. They cited a recent occasion where there were three support workers on during the morning. They felt that this was not enough as one of the support workers would have to spend a lot of their time doing medicine rounds. They said that a lack of staff happened "quite often." We looked at staff rotas and on only one occasion we saw there were less than four support workers on duty. When we discussed this with the manager, they told us although they ideally tried to have five support staff on duty, they felt that having four was manageable due to current occupancy levels. They also felt that domestic and kitchen staff were on hand to offer support, as well as staff from the providers' adjacent service and on this particular day a member of staff had gone off sick suddenly but the remaining staff managed using the other staff available in the service.

Records relating to the recruitment of new staff showed relevant checks had been completed before staff worked unsupervised at the service. These included employment references a Disclosure and Barring Service (DBS) check. These checks identified if prospective staff were of good character and were suitable for their role. This allowed the registered manager to make safer recruitment decisions.

People were given from their medicines from support workers who had completed medicine management training and were competent. We spoke with the manager, who informed us that competency checks were undertaken annually. Records confirmed this. People's medicines were provided in individually labelled boxes or bottles, which were stored in separate containers for each person within the medicine trolley, which was kept securely. Daily temperatures were recorded and were found to be within acceptable limits. A medicine fridge was available and minimum and maximum temperatures recorded.

The receipt, administration and disposal of medicines were recorded electronically on a medicine management system (EMAR). This meant that a clear audit trail of the use of medicines was possible and that staff were automatically alerted to any discrepancies, such as gaps in administration records. This included prescribed topical medicines, such as creams and lotions. The manager confirmed that they accessed a daily report relating to medicine management and a monthly stock check was also carried out. They said that the pharmacy provider had carried out a recent audit and that no major problems were found.

We observed part of a medication administration round and saw that the support worker was organised and safe practice was observed. They were wearing a tabard with 'Do Not Disturb' which highlighted to visitors and staff not to disturb them. Staff demonstrated an awareness of the needs and preferences of the people they administered the medicines to. Staff had received training to the EMAR administration system and that they had undergone competency checks. Where people had been prescribed trans dermal patches to be applied to their skin, the position the patch had been applied was noted on the EMAR.

A person who required insulin injections to control their diabetes had their blood sugar levels taken prior to being given their insulin. The amount of insulin required varied depending on the blood glucose level. Details of the required dose were available in order to direct staff. It was noted that the position of the injection was not being recorded. We spoke to the manager about this and they began to do this during the inspection.

Medicines were kept safely and where additional security was required this was recorded as required. Two signatures were evident for each administration. We checked the stock levels of three medicines, which were found to be correct. We observed the administration and saw that correct procedures were followed.

Where people had been prescribed medicines 'as required' (PRN) we found that protocols were in place to direct staff as to their use. This included prescribed topical medicines, such as creams and lotions. All protocols seen had been recently reviewed. People's care files contained medicine review sheets. These listed the current medicines people had been prescribed and indicated when they had been, or required review. It was noted that reviews for two people due in September 2018 had yet to be carried out. However, the deputy manager told us that these would be done. Information on the effects and use of medicines prescribed for each person was available on their EMAR.

The medicine management policy file contained a recent policy for homes using the Electronic Medication Administration Record (EMAR) system. There were no people receiving their medicines covertly; although a relevant policy was available. The policy referred to a best interest assessment procedure which included a capacity assessment involving the person, their advocates, GP and pharmacist.

Is the service effective?

Our findings

This continues to be an effective service

Some people using the service had capacity to make decisions about their care and were able to express their views and some people were not. Records showed that people had signed consent to share information with other professionals. Staff spoken with confirmed that they had received training in relation to mental capacity. The deputy manager in particular demonstrated a working knowledge regarding this, having been involved in capacity assessments, best interest decisions and DoLS applications. When asked what they did if a person refused their support one support worker stated, "You can't force anybody, you can only advise them; but I would record it."

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 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.

People's support plans were detailed and contained information such as, a personal psychiatric history, relapse risk factors, substance misuse, compliance with medicines and self-care. Staff knew people well and were knowledgeable about their needs. Records seen indicated that they had access to, and ongoing support from a number of healthcare professionals and services including GP's, dentists, chiropodists, opticians, hospital specialists and members of the community mental health social care team.

Staff completed an induction before working in the service. This covered the house, crisis management, risk assessments, the keywork relationship, recording & reporting systems, policy and procedures, medicines and fire safety. Staff received refresher training in areas such as safeguarding, infection control, food hygiene and mental health awareness, including the Mental Capacity Act. However, staff felt that training in specialist areas such as challenging behaviour would help them to be more effective in their role. The manager said that they would look into this.

Staff spoken with confirmed that they had received training appropriate to their role. This covered an introduction to the service, policy and procedures and fire safety. Staff received refresher training in areas such as safeguarding, infection control, food hygiene and mental health awareness, including the Mental Capacity Act. One member of staff described their induction where they had received five days specific induction training in a class room and then 'shadowed' experienced staff in order to learn about people's needs.

Staff confirmed that they had received supervision, although not annual appraisals. One member of staff said, "I had supervision recently and another one is booked, but I've never had an appraisal in six years". We spoke with the manager about this and they confirmed that they had not completed any appraisals since

taking over the service as they wanted to get to know staff before completing them to make them relevant to staff and their needs and now that they did they were beginning a timetable of them.

People had access to food and drink when ever they wanted it. Everyone we spoke with said how much they enjoyed the food. We observed lunchtime and saw that people had a choice of food and that portions were generous and people were able to have more if they wished. Comments included "The food is good here.", "There is always plenty, its on a two week rota". We were told those people who were able to access the community by themselves sometimes brought in takeaways or ordered food to be delivered with their own money. The support plans we reviewed contained monthly nutritional assessments that indicated there was no concern regarding loss of weight.

Is the service caring?

Our findings

The service remains caring.

People living at Serenita spoke very positively about the staff. They told us they were well cared for by staff that knew them well. Comments included; "I am completely satisfied with the caring service I receive", "The manager and the staff team show genuine care" and "An excellent caring service is provided". We saw staff and people living at the service interacted positively and looked comfortable together. Throughout the inspection we observed a lot of friendly 'banter' between people. Although we saw no visitors or relatives on our inspection, we were told that relatives and visitors would be welcomed in a caring and friendly manner.

People were treated as individuals and their choices and preferences were respected. This was reflected in people's feedback, "The staff know me so well" and "I go to bed exactly when I please and the staff help me with everything". We saw staff treat people with kindness, dignity and respect. Throughout the inspection we observed good practices which promoted people's privacy and dignity. For example, we saw staff respected people's privacy by knocking on doors and calling out before they entered their bedroom or toilet areas. Staff understood the need to respect people's confidentiality. Any information which needed to be passed on about people was done so in a discreet fashion. For example, during staff handovers, which was conducted in private space so information remained confidential. The service also had systems in place to ensure people's personal information remained confidential.

We looked at the services Statement of Purpose, which sets out their visions and values. We observed staff interactions encompassed the service's aims and values, such as supporting people's independence. We found the service supported people to express their views and be actively involved in making decisions about their care, treatment and support. People said they were encouraged to speak out at residents meetings, however we found that these had not regularly taken place since August when the activities co-ordinator left the service. The manager told us that they were re-instating these and hoped the new activities co-ordinator would facilitate these. The manager told us very few people attended advertised meetings so they were looking at changing the format to effectively increase people's level of engagement. From meeting minutes and speaking with people, it was clear that people's thoughts and ideas were acted upon.

The service had a range of information available in communal areas of the home to help people understand their care and support as well as access services externally. Information was presented in an accessible format, for example posters around the home used simple and clear text to promote people's understanding. We also saw useful information about the service's policies and procedures, such as how to raise a complaint. For people who wished to have additional support whilst making decisions about their care, information on how to access an advocacy services were displayed. This showed people had access to important information about their care.

Is the service responsive?

Our findings

The service remains responsive.

People needs were assessed prior to them moving in by the manager. This process ensured the service was able to meet the persons individual needs. Each person had a care plan in place. People were involved in the development of care plans where appropriate. Care records contained life history information and staff demonstrated they knew people well. One person said, "Staff are very knowledgeable." Records were detailed and up to date. They had a plan in place to address this. Daily care notes were completed by staff. This enabled staff coming on duty to get a quick overview of any changes in people's needs and their general well-being.

People were complimentary about the previous activity coordinator who, they said had the knowledge, skills and resources to support them in a range of activities. The home had an activity plan in place which was displayed on the notice board. This enabled people to know what was happening so they could make a choice as to whether to participate or not. People told us that since the activity coordinator had left the service, the range of activities had reduced, "There used to be lots of activities to do but now there are none, nothing to do at all except sit in my room and read." and "There is absolutely nothing to do here, no activities at all." We fed this back to the manager who was actively recruiting for a replacement and said that staff did offer activities with people and some people chose not to engage with them. The manager also told us that they had access to a minibus and regularly took people out. During the inspection we saw people helping prepare food, playing pool and engaging in pampering sessions with staff and with other people.

The provider had a clear complaints policy. The policy was displayed within the service and people received a copy when they moved in. All complaints and concerns had been fully investigated and responded to. One person told us, "I have no complaints". Another person said, "If I had any complaints I would speak to the staff, they are wonderful and would sort it out I am sure". However, some people told us that they were unsure of the complaints procedure but the manager assured us that everyone had a copy of the policy in their rooms they confirmed they would go through the policy again in the next residents meeting.

People had their end of life care wishes recorded as part of their support plan, where this had been identified as a need. Information was recorded about preferences for such things as who was important to the person, where people wanted to be and what they wanted to happen after they died. There was no one person at the time of the inspection receiving end of life care. The manager told us they would seek the advice from other healthcare professionals to ensure that the person would receive a dignified and pain free death. They would always try to enable people to remain at Serenita if that was their wish.

Is the service well-led?

Our findings

The service remains well led.

The service 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 service did not have a registered manager in post. The registered manager had left the service and another registered manager from another of the providers services' was currently in post and was intending to apply to register as the manager of Serenita as well. They were available throughout the inspection and told us that the deputy manager who had been at the service for some years was an asset to them as they were very knowledgeable about the people and staff.

People and staff told us the manager was approachable, they listened and acted on information that was presented to them. One person told us, "Yes I know her, she is really supportive to me". One member of staff said, "The new manager is extremely good and there has been additional staff employed. She is very approachable and will sort out any worries that you have. I would recommend the home yes."

Services are required to notify CQC of various events and incidents to allow us to monitor the service. The service had notified CQC of any incidents as required by the regulations. There was a management structure in the service which provided clear lines of responsibility and accountability. The manager and all members of staff understood what was expected of them. For example, the deputy manager was responsible for the procedures and processes around medication. The manager and staff team told us they loved being part of the team. One member of staff said, "I think we all deliver a good level of care. I would certainly let a member of my family have their care provided here."

The provider had a system in place to monitor the quality of the service staff delivered to people. Senior staff and the manager undertook a number of audits relating to the service. This was to ensure that, where needed, improvements were made. Audits covered a number of areas including medication, health and safety, environment, and care plans. The provider's area manager undertook various quality audits on a monthly basis. Areas for improvement had been noted by the manager and actions were underway to address these. For example, adding in "action taken" in the daily medicines handovers, so notes can be added if medicine stocks were low and more had been ordered

People had the opportunity to give their views on the quality of the service provided. There had been regular meetings for them to attend. One person said, "Yes I've been to the meetings. [Name of previous activity coordinator] used to let us know when they were". The manager assured us these would be beginning again.

The manager worked in partnership with other organisations to make sure they were following current practice, providing a quality service and people in their care were safe. These included social services, district nurses, GP's and other healthcare professionals.

