Serincourt Limited

Carleen Nursing and Residential Care Home

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

About the service:
Carleen Nursing and Residential Care Home 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. Carleen Nursing and Residential Care Home is registered to provide care for up to 40 people, including people living with nursing needs and dementia. At the time of the inspection, there were 35 people living at the service.

People's experience of using this service:
• People were happy with the care they received from the staff at Carleen Nursing and Residential Care Home.
• People told us they received safe care. People were supported by suitably trained staff.
• People received support to take their medicines safely and as prescribed.
• Risks to people's well-being and environmental safety were recorded and updated when the circumstances changed.
• People's rights to make their own decisions were respected. Staff supported people to make choices in line with legislation.
• People were supported to access health and social care professionals if needed.
• People's dietary needs were assessed and where required, people were supported with their meals.
• People were supported to participate in a range of activities of their choice.
• People were supported to be as independent as possible.
• Care plans were detailed and person centred. People were involved in deciding how they wished to be supported and in reviewing their care plans when needed.
• Staff were kind, patient and responsive to people's needs. People were treated with dignity and staff respected their privacy.
• People knew how to complain and were confident that if they raised concerns, the management would act promptly to address these.
• People and staff were fully engaged in the running of the service.
• The management team had effective quality assurance systems in place.
• The service worked well with other partners, organisations and commissioners.

The service met the characteristics of Good in all areas. More information is in the full report.

Rating at last inspection:
The service was rated as Good at the last full comprehensive inspection, the report for which was published on 14 November 2016.

Why we inspected:
This was a planned inspection based on the previous inspection rating.

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

Details are in our Safe findings below.

Is the service effective?

Good

The service was effective

Details are in our Effective findings below.

Is the service caring?

Good

The service was caring

Details are in our Caring findings below.

Is the service responsive?

Good

The service was responsive

Details are in our Responsive findings below.

Is the service well-led?

Good

The service was well-led

Details are in our Well-led findings below.

Carleen Nursing and Residential Care Home

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
Our inspection was completed by three 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.

Service and service type:
Carleen Nursing and Residential Care Home is registered to provide accommodation, nursing and personal care for up to 40 older people. At the time of the inspection 35 people were living at the home. The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
This inspection was unannounced.

What we did:
Before the inspection we reviewed the information we had received about the service, including previous inspection reports and notifications. Notifications are information about specific important events the service is legally required to send to us. We also considered information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we gathered information from:

- Nine people's care records.
- Seven people using the service.
- Four people's relatives.
- The service provider.
- The clinical director of care.
- The registered manager.
- The deputy manager.
- Seven staff members.
- The chef.
- Records of accidents, incidents and complaints.
- Audits and quality assurance reports.
- Records of recruitment, training and supervision.

Following the inspection, we gathered further information from:

- Two external healthcare professionals.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

People were safe and protected from avoidable harm. Legal requirements were met.

Systems and processes to safeguard people from the risk of abuse:
• All the people we spoke with told us they felt safe at Carleen Nursing and Residential Care Home. A person said, "Yes [I feel safe], there's always someone coming and going, you're not left on your own."
• The registered manager and staff knew what constituted safeguarding. Staff had received safeguarding training, which was updated annually.
• Staff were able to describe action they took if they suspected abuse. A staff member said, "I would report where I have to; to CQC or safeguarding, it's about keeping people safe."
• There were robust processes in place for investigating any safeguarding incidents. Where these had occurred, they had been reported appropriately to CQC and the local safeguarding team.

Assessing risk, safety monitoring and management:
• Risks to people were assessed, recorded clearly in their care plans and updated when people's needs changed.
• Risk assessments had been completed and identified possible triggers and actions staff needed to take to reduce the risks. For example, where people were at risk of falling, this was clearly documented in their care plan, which included information about equipment that was required to prevent falls from occurring; such as pressure alert mats.
• People who were at risk of malnutrition and dehydration had clear and up to date information within their risk assessment of how this should be monitored and managed by staff. This included information about their likes and dislikes of certain food and the implementation of food and fluid charts, so that their intake could be closely monitored.
• Other risk assessments in place included areas such as, moving and positioning, skin integrity, medicines management, the use of bed rails and behaviours.
• Staff had a good knowledge of potential risks to people and how to mitigate these risks.
• Equipment such as hoists and lifts were serviced and checked regularly.
• Environmental risk assessments and general audit checks of the home were done regularly and health and safety audits were completed.
• There were plans in place to deal with foreseeable emergencies. Staff were aware of the action to take in the event of a fire and fire safety equipment was checked regularly.
• Personal evacuation and escape plans had been completed for each person, detailing action needed to support people to evacuate the building in the event of an emergency.

Staffing and recruitment:
• There were sufficient numbers of staff available to keep people safe.
• Staffing levels were determined by the number of people using the service and the level of care they required.

• The registered manager used a dependency tool to help determine the number of staff required which they reviewed monthly. The registered manager said that although this dependency tool calculated the number of staff required they also observed care, spoke with staff and people, worked alongside staff and completed staffing level audits to ensure that staffing levels remained sufficient.
• There were thorough recruitment processes in place.
• Recruitment checks were completed before staff were appointed. This helped ensure suitable staff were appointed to support people.

Using medicines safely:
• People were supported to take their medicines safely.
• Medicine administration care plans provided clear information for staff on how people liked to take their medicines and important information about the risks or side effects associated with their medicines, such as the need for them to be taken at set times or what to do if a person refused their medicines.
• Medicines were administered by registered nurses who had been assessed as competent to do so safely.
• Medicines administration records (MAR) were completed correctly and indicated that people received their medicines as prescribed.
• There were suitable systems in place to ensure that medicines were securely stored, ordered and disposed of correctly and safely.
• Full stock checks of medicines were completed monthly to help ensure they were always available to people.
• Controlled drugs were stored in accordance with legal requirements.
• Safe systems were in place for people who had been prescribed topical creams.

Preventing and controlling infection:
• We found all areas of the home to be very clean and tidy.
• There were processes in place to manage the risk of infection and personal protective equipment (PPE), such as gloves and aprons was available throughout all areas of the home. Staff were seen using these when appropriate.
• The laundry room was clean, organised and measures had been taken to ensure the risk of infection was minimised. For example, there was a dirty to clean flow for laundry, which helped to prevent cross contamination.
• Infection control audits were completed regularly by a member of the management team and saw that actions had been taken where required.
• The staff were trained in infection control.
• There was an up to date infection control policy in place, which was understood by staff.

Learning lessons when things go wrong:
• There was a robust process in place to monitor incidents, accidents and near misses.
• Incidents, accidents and near misses were clearly recorded, acted upon and analysed.
• The director of clinical care completed monthly audits for all incidents and accidents that had occurred across all the provider's services. This helped to ensure that any trends or themes identified could be shared between services to help mitigate risk and prevent reoccurrence.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

People's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
• People and family members felt that the care was effective. A family member said, "The care is very good, I feel [my relative] is lucky she is here, we are very happy with it."
• Staff applied learning effectively in line with best practice, which helped lead to good outcomes for people and supported a good quality of life.
• Where appropriate, there was guidance for staff in people's files which reflected good practice guidance. An example of this was advice from the speech and language therapists when people were at risk of choking.

Staff support: induction, training, skills and experience:
• Staff had the necessary knowledge, skills and experience to perform their respective roles.
• Staff had undertaken effective and appropriate training in areas such as safeguarding, the Mental Capacity Act, infection control, moving and positioning and fire safety training.
• A staff member said, "We get a lot of training and I have re-done the care certificate. When I did it in my last job it was online but here it is more classroom based, which was much better."
• The registered provider had systems in place across their group of care homes to support the development of skills for registered nurses. This ensured they were up to date with current practice and able to meet the requirements of their registration with the Nursing and Midwifery Council (NMC). A healthcare professional said, "The nurses are knowledgeable."
• New staff had completed a comprehensive induction to the service and a probation period before being permitted to work unsupervised. A staff member told us, "I had an induction, it included basic training and then shadowing for about two weeks."
• Staff received one to one supervision with a member of the management team every eight weeks to discuss their progress and any concerns they had. Staff confirmed that they received these and that they found them helpful. A staff member said, "I have supervision, but I can raise concerns when needed and don't need to wait for supervision."

Supporting people to eat and drink enough to maintain a balanced diet:
• People were happy with the food provided. People's comments included, "It's good because you get three choices. On Friday it's the best one; fish and chips" and "There's plenty to eat. It's very nice. I've got no complaints, except they give you too much. You don't go hungry."
• Care records and food and fluid charts demonstrated people had choice and access to sufficient food and drink throughout the day and night.
• Where people were at risk of poor nutrition and dehydration, plans were in place to monitor their needs closely and professionals were involved where required to support people and staff.

• Individual dietary requirements were recorded in people's care plans and staff knew how to support people effectively.
• Menus were personalised to people's needs and preferences and people received a balanced diet.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care:
• A range of well-known tools were used to monitor people's health and wellbeing in line with best practice guidance. For example, staff used nationally recognised tools to assess people's pain levels, risks of developing pressure injuries and to monitor their bowel movements.
• The service received a weekly visit and video calls from the local doctor. The doctor said, "I feel Carleen approaching us about setting up this service shows commitment to give their patients the best care."
• Care records confirmed people were regularly seen by doctors, specialist nurses, dentists and chiropodists.
• The service ensured that people received consistent and coordinated care if they were required to move between services; such as requiring a hospital stay.

Ensuring consent to care and treatment in line with law and guidance:
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 were supported by staff that understood the principles of The Mental Capacity Act 2005.
• Records of mental capacity assessments and best interest decision meetings were recorded in people's care plans.
• Where people did not have capacity to make decisions, they 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 can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and found that they were.
• We found that applications for DoLS had been submitted to the appropriate authorities and approved where required.
• The management team and staff understood their role and responsibilities in relation to the MCA and DoLS. One staff member told us, "Some days people have capacity and some days they don't, but we always offer them choice."

Adapting service, design, decoration to meet people's needs:
• The environment and been designed and adapted to promote people's safety, independence and social inclusion.
• The home was well maintained, calm and homely and people could move around freely.
• There was a communal lounge, a dining room and a quiet area so people could socialise or spend time alone.
• Some decoration throughout the home supported people living with dementia or poor vision, which included picture signs on toilet, bathroom and bedroom doors and some hand rails of contrasting colours to the walls.
• Floors could be accessed by a passenger lift and stairwells and the flooring was suitable for people with mobility needs.
• People's bedrooms had been decorated to their tastes, together with some of their furniture and important

possessions.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; equality and diversity:
• Feedback from people and their family members reflected they felt that the staff were caring. Comments included, "They [staff] are all lovely" and "They are so kind. The girls are loving, caring and they make them feel at home, not that they are in an institution or a business."
• Staff were friendly and polite. Interactions between staff and people were natural and showed positive relationships had been developed. Throughout the inspection we heard staff speak to people respectfully and with kindness and check with people frequently that they were comfortable, warm and happy.
• The provider recognised people's diverse needs. There was a policy in place that highlighted the importance of treating people equally. Information about people's life history was recorded, which staff used to get to know people and to build positive relationships.
• People's protected characteristics under the Equalities Act 2010 were identified as part of their needs assessments. For example, we saw that where people had religious beliefs, they were supported to maintain their faith.
• Staff knew how people liked to be addressed and called people by their preferred name.

Supporting people to express their views and be involved in making decisions about their care:
• People told us they were fully involved in making decisions about their care. Comments included, "There's choice about going to bed at night" and "Although [my relative] can't speak, she can make her feelings known. She can show she doesn't want to get up and they say, 'Fine, we'll come back later.' They're happy to do anything she likes" and "The staff are very good and try to do what you want."
• People told us the staff knew their preferences well and knew how they would like their care to be delivered. A family member told us, "The night staff are lovely, the permanent staff. They've been here a long time, as long as [my relative] and they know her really well." Another family member said, "We said 'No male staff' because we'd noticed [our relative] looked frightened when a man came to help her. We asked if that was possible, and they said, 'Yes', and they've kept to it."

Respecting and promoting people's privacy, dignity and independence:
• Staff treated people with dignity and respect and provided compassionate support in an individualised way. A healthcare professional said, "Staff appear to treat the patients with great dignity."
• The service participated in a 'Dignity week' event; this included staff receiving additional training in dignity and then people and staff sitting down together and discussing and writing down what dignity meant to them.
• Staff respected people's right to privacy. Staff ensured they delivered personal care to people in private and there were signs on bedroom doors for staff to use so that no one interrupted personal care. Staff were seen knocking on bedroom and bathroom doors before entering. A person said, "They [staff] close the door

and pull the curtains. They always knock the door before they come in." A family member told us, "They knock the door and come in carefully, they're very attentive."
• The provider ensured people's confidentiality was respected. People's care records were kept confidential, staff had their own password logins to access electronic records.
• People were supported to be as independent as possible. Comments from people included, "They [staff] will ask if I need any extra help" and "They [staff] encourage you to wash yourself if you can. They are very good."
• People's care plans provided clear information for staff about what people could do for themselves and where additional support may be required. For example, one stated, 'I need assistance with all my personal care needs. I can wash my face and hands. I can choose my own clothes with support. I do not like to do my makeup.'

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:
• Staff knew the people they supported well and could describe how they wished to receive care.
• People's needs were outlined in care plans, there was clear information about what level of support was required.
• Staff knew people's likes and dislikes. They used this knowledge to care for people in the way they wanted. For example, care plans had very clear details around how a person preferred to be supported with personal care and tasks necessary to obtain desired outcomes.
• Care plans identified people's accessible communication needs: whether they needed glasses or hearing aids, and where staff should position themselves to speak to people.
• Staff were responsive to people's changing needs.
• People and their families if appropriate were involved when care plans were reviewed. Staff maintained links with family members living in other countries by email.
• People were provided with opportunities to participate in a range of activities. There were two activities coordinators in place and their role included; providing people with one to one support; such as reading to people, painting nails or an activity of the person's choice such as playing 'Scrabble'. We were told that the activities coordinators aimed to spend time with, or undertake an activity with, every person over two days.
• Group and social activities were organised which included visits from external entertainers. Once a fortnight there was an interactive music and movement programme to encourage mobilisation and socialisation. On the day of inspection, a presenter was featuring a well-known musical to stimulate discussion and song; which people clearly enjoyed.

Improving care quality in response to complaints or concerns:
• The provider had a robust complaints policy in place which was understood by staff.
• Two formal complaints had been received since the previous inspection. The registered manager was able to demonstrate these were investigated robustly; in a timely way and appropriate action had been taken were required.
• Information on how to make a complaint had been provided to each person when admitted and was displayed within the home.
• People told us they knew how to make a complaint and were confident that any concerns raised would be dealt with effectively. One person said, "I'm not afraid to make a complaint; I would do it through the nurses or the carers." A family member told us, "I did make one [complaint] and it was dealt with promptly. You need someone to listen."

End of life care and support:
• Staff told us no one in the home was very near the end of life, although we saw that anticipatory medicines had been ordered for a person when their health had declined. Some people were on palliative care

pathways due to their frailty.
• The registered manager and staff were able to provide us with assurances that people would be supported to receive good end of life care and effective support to help ensure a comfortable, dignified and pain-free death.
• Staff had received training in end of life care and demonstrated that they understood this.
• A healthcare professional said that the end of life care provided by the staff at Carleen was, "Always excellent. I have no concerns."
• Feedback received from a relative stated, 'Your care and dedication not only extended [the persons] life for months but gave them back the quality of life they thought they had lost.'
• People's care plans contained detailed information about people's individual end of life wishes. These included information about where the person wanted to be at the time of their death and how they wished their body to be cared for.
• Staff had access to a range of best practice guidance and resources available to them, which helped them to provide support to people to live well before dying with peace and dignity in the place of their choice.

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility:
• People and their relatives felt the service was well led and all told us they would recommend the home to others. One person told us, "Yes, I think I would (recommend the home)." A relative said "I would (recommend the home); there's always some activity going on."
• A healthcare professional said, "It seems very well led. The manager is forward thinking and always trying to improve things. I was particularly impressed how she doesn't micro-manage the nursing staff. For example, the lead medical management nurse is empowered to discuss changes with me. The nursing staff and I have discussed various medical management issues and apart from a brief oversight it is clear that the manager is empowering her staff."
• The management team and staff demonstrated a commitment to provide person-centred, high-quality care by engaging with everyone using the service and stakeholders.
• The previous performance rating was prominently displayed in the reception area.
• The provider had a duty of candour or policy that required staff to act in an open and transparent way when accidents occurred. This was discussed with the registered manager who was able to demonstrate that this was followed when required.
• The registered manager understood their responsibilities and had notified CQC about all incidents, safeguarding concerns and events that were required.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:
• There was a clear management structure in place, consisting of the provider, wider management team; which included a clinical director of care and human resources manager, a registered manager and a deputy manager; each of whom had clear roles and responsibilities.
• Staff understood the provider's vision for the service and they told us they worked as a team to deliver support that met the needs of individual people.
• All the staff spoken to were very positive about the running of the service and spoke highly of the management team. Comments included, "The registered manager has made lots of changes and we can see that things are really good now and systems are in place that work", "She's (registered manager) been a really positive influence and steps in when needed" and "I see the owner regularly; he always asks us how we are and it makes me feel really valued."
• Extensive policies and procedures were in place to aid the smooth running of the service. For example, there were policies on equality and diversity, safeguarding, whistleblowing, complaints and infection control.

• There were robust quality assurance procedures, which included audits of care plans, cleaning records, medicine administration and stock, environmental audits, training and food safety.
• All completed audits resulted in an action plan being completed, where required. These were discussed with the wider management team and timescales for work to be completed, agreed.
• The registered manager felt supported by the provider and wider management team. The registered manager said the provider visited the home a number of times per week and was fully involved in the running of the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:
• People and their families were given the opportunity to be fully involved in the running of the service.
• The management team created opportunities for people to provide feedback. For example, people had regular reviews, during which they could provide feedback about the care and the service received. Regular meetings were held for people who used the service and their families and quality assurance questionnaires were sent to people, families, staff and professionals annually.
• The management team monitored all feedback received. For example, information from the latest quality assurance questionnaires was collated and action was taken where required.
• A weekly newsletter was produced, which provided people with updates of activities, changes to staff and wider changes and news about the home and service.
• People and families were also provided with the opportunity to make anonymous comments though the use of a sealed comments box with was regularly reviewed by the registered manager.
• Where people had made suggestions or shared ideas about the running of the service, these were taken seriously by the management team, considered and if appropriate acted upon. For example, following people's suggestions a porch had be put in place and an additional disabled parking space had been added to the car park.
• People's individual life choices and preferences were met. The registered manager was clear how they met people's human rights. For example, supporting people to attend religious services and supporting relationships.
• Staff were kept up to date through regular staff meetings; supervision and handover meetings between shifts.

Continuous learning and improving care:
• There was an emphasis on continuous improvement.
• The registered manager and wider management team monitored complaints, accidents, incidents and near misses and other occurrences on a monthly basis or more frequently if required. If a pattern emerged, actions would be taken to prevent reoccurrence.
• Staff performance was closely monitored by the management team. If performance fell below the standard of care expected, the management team dealt with these by taking appropriate action; which could include retraining and increased supervision.
• All learning was shared with staff during staff meetings, handovers and supervision.

Working in partnership with others and community involvement:
• The service worked well and in collaboration with all relevant agencies, including health and social care professionals. This helped to ensure there was joined-up care provision.
• Staff supported people to attend local community events and to access activities and support from external agencies.
• The service had links with other resources and organisations in the community to support people's preferences and meet their needs.
• The service hosted an in-house coffee morning and craft market which was open to the local community to

attend.
• Links had been developed with a local school to provide pupils with work experience.
• A play group was held at the home every two weeks which invited preschool children and their parents to mix with people living at Carleen. We were told by a staff member that this was well received by the people living at the home.