Care South

Talbot View

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

This comprehensive inspection took place on 15 and 17 May 2018. The first day was unannounced. Talbot View 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.

Talbot View accommodates up to 59 people in four 14 or 15-bedded wings of purpose-built premises. There were 41 people living or staying there when we inspected. The two wings downstairs specialise in providing care to people living with dementia. The two wings upstairs are for people who require residential care due to frailty, illness and impairment in their old age. One of the upstairs wings was closed for refurbishment at the time of the inspection.

The service had a registered manager but they had left a few weeks previously and were due to apply to cancel their registration. The current manager had been in place since the registered manager left. They had applied to register with CQC and were awaiting a fit person interview. 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 were treated with kindness and compassion. Staff knew and respected the people in their care. People's privacy, dignity and independence was respected and promoted.

People were protected from abuse and neglect. Staff knew how to raise concerns about poor practice and suspected wrongdoing under the provider's whistleblowing procedures.

People's rights were protected because the staff acted in accordance with the Mental Capacity Act 2005, including the deprivation of liberty safeguards. Where people were able to give consent to aspects of their care, staff sought this before providing assistance. If there were concerns that people would not be able to consent to their care, staff assessed their mental capacity. Where they were found to lack mental capacity, a decision was made and recorded regarding the care to be provided in the person's best interests.

Risks to people were assessed and managed in the least restrictive way possible. People were supported to take risks to maintain their independence as far as possible, for example, if they were able to walk they were encouraged to do so.

Some people living with dementia were on occasion reluctant to accept support with care, which could cause them to become distressed when staff attempted to assist them. The service had taken advice from specialist healthcare professionals. This had reduced the frequency of behaviour that challenged others.

People's physical, mental health and social needs were assessed holistically, and individualised care was

planned and delivered to meet these. Staff had a good understanding of people's care needs.

People were supported to express their views and to be involved in decisions about their care.

People were supported to maintain a balanced diet and to have plenty to drink. People's weights were monitored and appropriate action taken if people were identified as being at risk of malnutrition, such as pursuing referral to a dietitian. Similarly, if people were observed to have difficulty swallowing, a swallowing assessment was sought with a speech and language therapist.

Group and individual activities were based on people's interests and needs. They were facilitated by an activity coordinator and designated care staff.

People had access to healthcare services and were supported to manage their health.

At the end of their lives, people were supported to die in comfort and with dignity.

There were sufficient safely recruited, competent staff on duty to provide people's care and support. Staff had access to the training they needed.

Staff were positive about their roles and told us they were well supported by the provider and manager.

Medicines were stored securely and managed safely.

Equipment and facilities throughout the home had been checked and serviced regularly.

The premises were clean, free from clutter and odours, creating a pleasant living space for all the people living at Talbot View.

Lessons were learned and improvements made when things went wrong. Concerns and complaints were seen as an opportunity to bring about improvement. The manager and their team exercised their duty of candour, keeping people and where appropriate their relatives informed about what had happened as the result of an accident or incident.

The service operated openly and transparently, working cooperatively with other organisations to ensure people were safe and received the care and support they needed. There was open communication with people who used the service, their relatives and staff about developments and changes at the service. The manager spent time speaking with people. There were also meetings for people who used the service, their relatives and staff.

Quality assurance systems were in place to learn from current performance and drive continuous 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 was safe.

Risks were managed safely, with the minimum restriction possible.

There were enough competent staff on duty to provide the care people needed. Pre-employment checks were robust.

Medicines were managed safely.

Is the service effective?

Good

The service was effective.

Staff were supported through training and supervision to be confident and capable in their work.

People had a choice of food and drink across the day.

Staff made timely referrals to healthcare professionals, and acted on their recommendations.

Is the service caring?

Good

The service was caring.

People were treated with dignity, respect and kindness.

People, and where appropriate their families, were involved in decisions about their care and support.

People's right to privacy and confidentiality was respected.

Is the service responsive?

Good

The service was responsive.

Care planning was focused on the person's whole life, including their goals, skills, abilities.

People who used the service and their visitors felt confident that

if they complained, this would be taken seriously.

People were supported to make decisions about their preferences for end of life care.

Is the service well-led?

Good

The service was well led.

The manager was available to people and staff and led by example.

Management systems identified and managed risks to the quality of the service. This information was used to drive improvement.

The culture of the service was positive, open and person-centred.

Talbot View

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.

CQC was made aware of concerns that someone had not received all the care they should have done, that their medicines had not been handled safely and that staff had not always received supervision. We took these concerns into account in planning what we would consider at this inspection.

This was a comprehensive inspection. It took place on 15 and 17 May 2018. The first day was unannounced. The inspection team comprised an adult social care inspector and an expert by experience on the first day. The adult social care inspector and an assistant inspector returned on the second day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service, in this case care for older people.

Before the inspection we reviewed the information we held about the service. This included incidents they had notified us about. We also obtained feedback from a member of the local authority safeguarding team who had been overseeing a safeguarding enquiry relating to someone who used to live at the service. A Provider Information Return had not been requested within the year prior to the inspection. A Provider Information Return 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 met people who were living or staying at Talbot View and spoke with 15 of them, 7 at more length. We also spoke with four visitors, five care and activities staff, two ancillary staff, the home manager and the nominated individual. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not tell us about their experiences. We also made general observations around the service and reviewed records. These included four people's care plans and records including their medicines records, four staff files, quality monitoring audits, accident and incident records and other records relating to the management of the service. We obtained feedback from a further healthcare professional following the inspection.

Good

Is the service safe?

Our findings

People were protected from abuse and neglect. People told us they felt safe with the staff. Information was available for people and staff about how to report concerns about abuse and neglect, both within the service and to statutory agencies concerned with safeguarding people. Staff had a good understanding of the reporting procedure and told us they would not hesitate to blow the whistle on poor practice.

Risks to people were assessed and managed in the least restrictive way possible. A relative's comment illustrated this: "Their skills are self-evident; [person] is not confined and is actually encouraged to get about herself. This sometimes leads to her falling over, but this has been discussed with us and the risk has been assessed. They are concerned about preserving her independence and her quality of life. We are totally supportive of this approach." Risk assessments covered areas such as moving and handling, falls and fractures, malnutrition, vulnerability to pressure sores and the use of bed rails. People's care plans took these into account. Risk assessments were reviewed monthly or every three months, or in between if people's needs changed. People were encouraged to take risks to maintain their independence as far as possible. For example, people who were able to walk were encouraged to do so rather than using wheelchairs for the convenience of staff, even though this would increase their risk of falls. Bed rails were not used if there was a risk that people might climb over them.

Some people living with dementia at times behaved in a way that was challenging for others to observe or manage. In particular, this related to people sometimes being reluctant to accept support with care, which could cause them to become distressed when staff attempted to assist them. A dementia in-reach nurse had provided advice and guidance in developing care plans for these people's essential care. The home manager and staff told us they had found this guidance very helpful. Incidents of behaviour that challenged had reduced over the past couple of months, and people received the care they needed.

There were sufficient staff on duty to provide people's care and support. For example, a person who lived at Talbot View told us they could not recall being kept waiting and that staff responded when they rang their bell. A relative commented, "The staff are proactive, if [person] rings the bell they come straight away; nothing is too much trouble." One person said staff did seem very busy at times. Whilst staff were busy, they supported people without rushing them. Gaps in the rota, for example due to staff sickness, were covered by agency staff. The provider had an arrangement with a particular agency, which meant that wherever possible agency staff were familiar with the service. We observed an agency worker supporting people confidently and sensitively.

Staff were safely recruited following checks including previous employment, reasons for any gaps in employment, references and criminal records checks with the Disclosure and Barring Service. Most staff had worked at the service for several years.

Medicines were stored securely and managed safely. Staff observed people whilst they took their medicines. There was a computerised medicines recording system, which identified if stocks were running low or there was no explanation for why a medicine due at a particular time had not been given. Some people who

lacked capacity to consent to medicines administration but refused to take medicines had their medicines disguised in food or drink. This was subject to a Mental Capacity Act 2005 best interests decision, with the involvement of a GP and a pharmacist. Medicines stocks were audited at least twice a month. Staff who handled medicines were trained to do so and were observed at least annually to check they were competent.

The premises and equipment were well maintained. Décor was in good order, although the provider acknowledged that some areas looked drab and were planned for refurbishment. Equipment and facilities throughout the home had been serviced regularly. For example, hoists and lifting bath seats were checked six monthly, most recently on the first day of the inspection. There were regular checks on maintenance, health and safety and fire alarms and equipment. Timed practice fire evacuations took place every few months.

The premises were clean, free from clutter and odours, creating a pleasant living space for all the people living at the home. A person commented: "It's always very clean". The service had obtained a five star food hygiene rating (the highest). Staff were trained in infection prevention and control, including hand hygiene. They used protective equipment, such as disposable gloves and confirmed this was readily available. Staff wore washable tabards when assisting people at mealtimes.

Lessons were learned and improvements made when things went wrong. There were clear reporting procedures for accidents and incidents. The home manager or deputy reviewed each incident reported to ensure all immediately necessary action had been taken for people's safety and wellbeing. The home manager made a monthly review to identify any possible trends, such as incidents involving particular people. Incidents had been logged on the provider's electronic recording system as they arose, even if there was no apparent injury. Accidents and incidents were reviewed at the provider's board meetings. The board received reports on any situations where there had been multiple incidents, including actions taken or in progress. Lessons learned were shared across the provider's services to improve the safety of all who used them.

Good

Is the service effective?

Our findings

People's physical, mental health and social needs were assessed holistically, and care was planned and delivered to meet these. Needs were assessed in outline before people came to stay, so the service manager could be sure Talbot View was able to provide the care needed. Protected characteristics under the Equality Act, such as religion and sexual orientation were considered as part of this process, if people wished to discuss these. Assessments and care plans were reviewed regularly with the involvement of people and their relatives. The manager had introduced a 'resident of the day' scheme to ensure this happened, with people and their families having the opportunity to express any concerns they had. 'Resident of the day' also gave senior care staff an opportunity to notice any changes in health and take appropriate action to maintain people's health and wellbeing. The manager ensured each person had contact with the kitchen, maintenance department and the activities department so they could tell them what their likes and dislikes were. This helped ensure people received individualised care.

Staff had the skills and knowledge to provide effective support. People and visitors spoke highly of the quality of their care. For example, comments included, "I can say that the care is excellent and the staff are wonderful" and there was a reference to "highly trained" staff. Staff were able to undertake necessary training. The provider operated an in-house learning and development department that organised and facilitated training. The manager told us, "If you explain why you need training they will organise for you, even if it's external." Staff new to care were expected to complete the Care Certificate, which covers a nationally recognised set of standards for workers in health and social care. Core training, such as moving and handling, safeguarding and fire safety, was refreshed annually. Other training of relevance to staff was also available. Training and development needs were considered during staff supervision and annual appraisals.

People were supported to maintain a balanced diet and to have plenty to drink. People and relatives were positive about the food and told us they had a choice. Comments included: "The food is always good; if I don't fancy what's on the menu they will always offer me an alternative. It's never a problem" and "The food is good." The daily menu was available in the dining room on each unit. People who had difficulty remembering what was on the menu were shown plated meals at mealtimes to help them choose. Meals looked appetising. Cultural and health-related dietary needs and preferences were documented in people's care records, and food was provided accordingly. Where people required assistance from staff to eat their meal, this was provided sensitively, at the person's pace.

People's weights were monitored and appropriate action taken if people were identified as being at risk of malnutrition, such as pursuing referral to a dietitian. Similarly, if people were observed to have difficulty swallowing, a swallowing assessment was sought with a speech and language therapist. A relative commented, "When [person] first came here they would not eat, the staff know exactly how to treat them and [person] now eats like a horse." Where speech and language therapists had devised safe swallow plans, up-to-date copies were available for kitchen staff. Nutrition care plans were also made available to kitchen staff; new versions were not always provided when updated, although staff did communicate critical information such as allergies and swallowing difficulties. The manager had identified this as an area for

improvement. People at risk of choking or aspiration were provided with thickened fluids and mashed or pureed foods in accordance with their safe swallow plan.

People had access to healthcare services and were supported to manage their health. A person remarked, " [Staff get] the optician, dentist, chiropodist, doctor of our choice if we want it, anything we want they will arrange on our behalf." Healthcare professionals told us staff communicated well with them and followed their advice. When people appeared unwell or asked to see a doctor, staff organised for the doctor to visit. District nurses regularly visited the service and staff also liaised with them. Each person had a hospital transfer form, which summarised their main care needs in the event they needed to go into hospital. The service had recently introduced improved mattresses as standard, as part of the provider's programme for reducing the incidence of home-acquired pressure sores.

The building was purpose built as a care home, with individual bedrooms with ensuite toilets and basins on the ground and first floors. People had personalised their rooms with pictures and possessions. Outside people's rooms were memory boxes containing pictures and objects of significance to each person, to help them recognise their room. Each unit had a dining room, a lounge, a large hallway area with seating, and a kitchenette. There were shared toilets, shower rooms and bathrooms adapted for people with mobility difficulties. Toilets were clearly signed with a label and a large picture of a toilet. The downstairs areas had direct access to gardens with seating, paved areas, lawns and planting. People living upstairs came downstairs to the garden. There was car parking on site.

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's rights were protected because the staff acted in accordance with the MCA. Where people were able to give consent to aspects of their care, staff sought this before providing assistance. If there were concerns that people would not be able to consent to their care, staff assessed their mental capacity. Where they were found to lack mental capacity, a decision was made and recorded regarding the care to be provided in the person's best interests. People were involved as far as possible in this process and the relevant people, such as close relatives, were consulted. Examples of best interests decisions related to providing care, administering medicines, and the use of bed rails to prevent falls from bed.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The management team had identified where people were being deprived of their liberty and had applied to the relevant supervisory body to authorise this. There was a system for tracking the expiry date of DoLS authorisations and ensuring applications for renewed authorisations were made in time.

Good

Is the service caring?

Our findings

People were treated with kindness and respect. People and visitors described the staff as caring. Comments included: "They [staff] are always approachable", "[Person] is treated kindly", "The staff are lovely and I am treated very well" and, "I am very happy here; the staff are marvellous – they really do care about us all." Staff interacted with people patiently and sensitively, responding promptly to their needs. They did so in a professional manner, with affection and humour, and people responded positively to this. For example, when staff were assisting people to transfer between their chair and a wheelchair using a hoist, they did so gently, telling them what they were doing and reassuring them. This helped people to remain calm and comfortable.

People received care and support mostly from staff who knew them well. All of the staff we met knew and respected the people in their care. This showed in how they spoke about people, as well as in how they interacted with them. Staff were able to tell us about people's histories, preferences and interests, and things that people were concerned about. Information about life history, hobbies and interests, and likes and dislikes was gathered when people moved in, to help with planning and providing care and activities.

People were supported to express their views and to be involved in decisions about their care. They, and where appropriate their relatives, reviewed their care monthly with the member of staff who was their key worker, as part of the 'resident of the day' process. People had personalised their rooms with pictures, photographs and other objects from home. People told us, "My room is lovely. It has been personalised with all my own things" and, "I can get up when I want to and have what I want for breakfast." Relatives and friends were able to visit unannounced whenever they and the person they were visiting wished. A person commented, "I have several regular visitors, friends and family. They enjoy coming here as much as I enjoy having them. The staff are very accommodating."

People's privacy, dignity and independence was respected and promoted. Assistance with personal care was offered discreetly and provided behind closed doors. Care records were stored securely, out of public view. People were encouraged to be as independent as possible. They told us staff provided the right level of support, not too much and not too little. Someone told us how they themselves organised appointments with some healthcare professionals. Care plans reflected what people could do for themselves, such as when washing and getting dressed. People were encouraged and supported to maintain their mobility. We observed people moving slowly and independently, being enabled to do so.

Good

Is the service responsive?

Our findings

People received individualised care according to their needs. Staff had a good understanding of care plans, which were personalised according to people's personal histories and preferences. Care plans covered areas such as communication, pressure area care, moving around, eating and drinking, personal hygiene, continence and care at night. Where people frequently declined personal care, there were plans for 'essential care'. These had been devised in consultation with nurses from the local dementia in-reach team. They set out the minimum frequency for aspects of personal care, such as washing the upper and lower body and brushing teeth, that would not adversely affect health and wellbeing. These plans set out strategies for staff to try to get people to accept care, rather than compelling people to have care, and who should be contacted if people continued to resist.

An activity coordinator facilitated group and individual activities based on people's interests and needs. They were assisted by designated care staff as the other activity coordinator post was vacant, although recruitment to the vacant post was under way. Activities included regular armchair keep fit sessions. We observed one of these sessions; people smiled and responded positively, while others who chose not to take part moved their heads and tapped their feed to the music. Forthcoming activities included a Royal Wedding street party event; staff were putting up decorations ready for this. Young people undertaking the Duke of Edinburgh award assisted with some activities. The manager told us how they hoped to develop further community links, such as with local schools.

The service met the Accessible Information Standard. The Accessible Information Standard is a law that aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. People's sensory loss and communication needs were flagged up in assessments, care plans and hospital transfer forms. Staff provided the support people required in these areas.

Concerns and complaints were seen as an opportunity to bring about improvement. People said they felt they would be able to complain to the manager. Information about how to make a complaint was available in communal areas. There had been one complaint recorded in 2018. This was addressed promptly and thoroughly.

People were supported, at the end of their lives, to die in comfort and with dignity. Staff liaised with GPs and district nurses to provide the support needed, for example ensuring that anticipatory end-of-life medicines were in place. Staff discussed with people and their families preferences regarding end of life care, if they were willing to discuss this. 'What I want for the future' documents recorded any preferences people had, such as whether they would prefer to die at Talbot View or in hospital.

Good

Is the service well-led?

Our findings

Talbot View had an open, informal culture. A relative said, "The atmosphere is friendly and homely." People knew the manager, who had arrived at the service only a few weeks before. Comments included: "The staff all work together as a team, and the manager is always present – she comes round every day and talks to us all individually" and "[manager] Comes in to speak to us every day." The manager spent time in the residential areas and was clearly well known to people. The manager told us, "It's their home, I need to know what they want."

Staff were positive about their roles and told us they were well supported by the provider and manager. Comments included: "I love coming to work" and "I love it here". There was a consistent staff team, many of whom had worked at the service for a number of years. The manager had an open door policy. They and the duty manager worked alternate early mornings, evenings and weekends to be available for staff. Staff were supported through observed practice and supervision meetings, which were called 'Heart to Hearts' and based on the provider's HEART values: honesty, excellence, approach, respect and teamwork. Agendas for supervision were flexible according to what the staff member needed or wished to discuss. Supervision records reflected a relationship of professionalism and compassion, focusing on areas done well and encouraging improvement. The manager had recognised since arriving a few weeks before that supervision meetings were not always taking place as often as specified by the provider's supervision policy. They had started addressing this.

The service operated openly and transparently, working cooperatively with other organisations to ensure people were safe and received the care and support they needed. The manager and their team had exercised their duty of candour, keeping people and where appropriate their relatives informed about what had happened as the result of an accident or incident. Staff knew how to raise concerns about poor practice and suspected wrongdoing under the provider's whistleblowing procedures.

There was open communication with people who used the service, their relatives and staff. As well as the manager's informal conversations with people, there were residents and relatives meetings. At these meetings people were kept informed about changes occurring at Talbot View, expressed ideas and wishes for new activities, and had the opportunity to pose questions. Staff received updates about the service at staff meetings, at which they were encouraged to contribute their points of view. For example, the provider was changing working patterns to 12 hour shifts. This had been discussed openly with Talbot View staff, who had engaged with the changes. There was a new screen in the entrance hall that displayed the inspection rating and gave information about forthcoming events.

Quality assurance systems were in place to learn from current performance and drive continuous improvement. The manager had recently started in post and had applied to register with CQC. They had already completed audits and identified several areas for improvement. This included the regular checking of bed rails to keep people safe, timely supervisions and appraisals, and ensuring nutrition care plans were up to date and shared with the head chef. A sling audit had been completed which identified some people only had one sling; this was in the process of being rectified. The manager was supported by their line

manager, who visited the service regularly, and the provider's senior management team. This included periodic audits by the provider's quality team. The provider had introduced a new incident reporting system that gave the board and senior management team contemporaneous information that could be interrogated and analysed, rather than relying on monthly returns from the service.