Maycroft Care Home Limited

Maycroft Care Home

Inspection report

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Date of inspection visit:
09 July 2018

Date of publication:
03 August 2018

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

Maycroft Care Home is a residential care home that provides accommodation and personal care for 25 older people with dementia or a physical or sensory impairment. There were internal and external communal areas for people and their visitors to use. The service is situated over two floors and these were accessible by stairs or a passenger lift.

Maycroft Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

At our last inspection on 18 February 2016 we rated the service good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

There was a registered manager in post at the time of this inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were supported by staff who knew about safeguarding and its reporting processes. Risk assessments were in place as guidance for staff to support and monitor people's assessed risks. People's care records were held securely to ensure confidentiality. People had technology in place to help assist them to receive safe care and support.

Staff had been recruited safely prior to working at the service. People's needs were met as there were enough staff with, right skills and knowledge. Staff were trained to meet people's care and support needs. Actions were taken to learn any lessons when things did not go as planned.

People's medicines were administered as prescribed and managed safely. Systems were in place to maintain infection prevention and control.

People were involved in their care decisions and staff promoted people's independence as far as practicable. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible.

People were supported with their eating and drinking to promote their well-being.

Staff supported people to access external healthcare services. Staff worked with other organisations to help ensure that people's care was coordinated. Staff also worked with other external health professionals to make sure that peoples end-of-life care was well managed and dignified.

People received a caring service by staff who knew them well. People's privacy and dignity was maintained by staff.

Activities were in place to support people's interests and well-being, including links and trips out to the local community.

Compliments were received about the service and people were happy with how their complaints were managed as any complaints were responded to and resolved where possible.

The registered manager led by example and encouraged an open and honest culture within their staff team. Audit and governance systems were in place to identify and drive forward any improvements required. The registered manager and their staff team worked together with other organisations to ensure people's well-being.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains good.	**Good**
Is the service effective? The service remains good.	**Good**
Is the service caring? The service remains good.	**Good**
Is the service responsive? The service remains good.	**Good**
Is the service well-led? The service remains good.	**Good**

Maycroft Care Home

Detailed findings

Background to this inspection

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

This comprehensive inspection took place on 9 July 2018 and was unannounced. The inspection was undertaken by one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was older people and people living with dementia.

Prior to the inspection we used 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 the improvements they plan to make. We reviewed other information we held about the service to aid with our inspection planning. This included past inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We also contacted other health and social care organisations such as representatives from the local authority contracts and quality team; Healthwatch, the local safeguarding authority and a specialist mental health practitioner. This was to ask their views about the service provided. Their views helped us in the planning of our inspection and the judgements we made.

We spoke with nine people living at the service who could give us their views of the care and support they received. We also spoke with two visiting relatives/friends. We also observed staff interaction throughout the inspection. We spoke with the registered manager, the head chef; the chef; the deputy manager; two care assistants; a social facilitator; an activities co-ordinator; maintenance person and a laundry assistant.

We looked at care documentation for two people, medicines records, three staff files, staff supervision, appraisal and training records. We also looked at other records relating to the management of the service including audits and action plans; accident and incident records; surveys; meeting minutes and complaint

and compliment records.

Good

Is the service safe?

Our findings

The service remains good. People confirmed to us that they felt safe. One person said, "I feel safe here, I can go where I like." Staff had completed training on how to safeguard people from harm and poor care and they understood their responsibility to protect people. They told us they would report any concerns both internally to management and to external agencies, in line with the service's processes. Staff were also aware of how to whistle-blow. This is a process where staff are provided a safe arena to report any poor standards of care.

People's care records and risk assessments were held securely. Information within people's risk assessments gave clear guidance for staff to follow to deliver safe care and minimise risk. Staff monitored and reviewed people's risk assessments following any deterioration in people's needs. People also had emergency evacuation risk assessments in place to assist them to evacuate safely in the event of an emergency such as a fire.

Equipment and technology was used to assist people to receive safe care. We saw that there were call bells and sensor mats in place for people to summon or alert staff when needed. A sensor mat is alarmed and alerts staff of movement; they are used where people are at risk of falls.

A person told us, "They have plenty of staff around," and this was confirmed during our observations. We saw that there were enough staff with the right skills mix to meet people's needs. Staff promptly answered call bells. Staff told us that recruitment checks were in place prior to them working at the service. These checks made sure that the right staff were recruited to the role, they were appropriate to work with people and were of good character.

Medication was stored securely, maintained at the correct temperature and disposed of safely. Records showed that medication was administered as prescribed. Any medication errors were reported and investigated and the relative of the person involved were also made aware. Staff administering medication had received training and their competency had been reviewed by senior staff.

The service managed the control and prevention of infection. Staff knew about their role in preventing the spread of infection and told us that they had enough cleaning equipment and personal protective equipment (PPE) available to use. This equipment was for single use only to help reduce the spread of infection.

Staff gave us examples of shared learning that took place with them regarding any incidents or near misses. This was to reduce the risk of recurrence. Shared learning was communicated to staff at daily handovers and, or, during staff meetings.

Good

Is the service effective?

Our findings

The service remains good because people's assessed needs continued to be met by staff. Staff used guidance from social and healthcare organisations to provide care based upon current practice to support people with their care needs. For example, their medication policy reflected guidance from The Royal Pharmaceutical Society in the safe management of medication in social care.

Staff attended supervisions and appraisals to support them in their day-to-day role and to help identify and discuss any learning needs. Staff were also supported to maintain their current skills with regular training on mandatory core subject areas relevant to their role. All care staff were encouraged to develop their skills and knowledge by completing a diploma in health and social care.

People had a choice of food and drinks. Staff used visual prompts of plated up food to help people make a choice at mealtimes. High calorie and fortified foods were given to people identified at risk of malnutrition. These foods provided additional nourishment to people to promote or maintain their weight. Mealtimes were a positive experience which people enjoyed and people were encouraged to sit where they wished, including the garden to enjoy their meals. There were positive comments from people about the food, for example one person told us, "The food here is good." People were encouraged to increase their fluid intake during the hot weather and this included lollies and ice creams as well as hot and cold drinks being on offer.

Staff enabled people to access external healthcare services to promote their well-being. The registered manager and staff team worked with external organisations such as speech and language therapist teams, community nurses and health practitioners. Relatives confirmed to us that they were kept informed of any changes in their family members health by staff.

Adaptations to the building such as hand rails and ramps for wheelchair access enabled people to mobilise more easily and access the gardens and other areas. Memory boxes and pictorial signage were used to support people with dementia with recognition and signage with braille supported people with sensory impairment with their orientation. Braille is a tactile writing system used by people who are visually impaired.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The service was continuing to work within the principles of the MCA. Principles of DoLS had been considered for people living in the service and applications to relevant authority were made where required. 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. For example, we saw that people had free access to all areas of the service and choices of when they would like to get up or what they wanted to wear.

Good

Is the service caring?

Our findings

The service remains good because staff treated people with compassion, kindness and respect. One relative said," I see the kindness from the staff and their patience." Another relative told us," It's a good atmosphere. [Family member] is much happier here than [they] were in the other home, this is better all round."

Our observations showed that staff knew the people they were supporting well, knew their preferences, listened to them and communicated to them in a way they understood.

People and their relatives told us that they were encouraged to express their views and were involved in the decisions about their or their family members care. Meetings were held to inform people and their relatives with updates about the service provided. Records showed that discussions to consult with people and their relatives about the move into a new purpose-built building on site had taken place. A person told us, "Yes I know about the new build, should be better, more room." These meetings were also a place where people could make suggestions or raise any concerns they may have had. For example, following popular request there were now more and varied activities for people to participate in.

Information was available around advocacy services should people or relatives need this information and advice. Advocates are independent and support people to make and communicate their views and wishes.

Observations showed that people's dignity and privacy was promoted by the staff supporting them. Staff knocked on the door of people's doors before entering their rooms and personal care was carried out behind closed doors to maintain people's privacy. Staff bent down beside people who were seated, so that they could communicate and talk with the person at eye level. This helped the person feel more in control of the situation and not feel intimidated. People recognised staff, interacted with them and often rewarded them with a smile.

Staff, although busy, assisted people at the persons preferred pace. Staff carefully explained to people what they were going to do before helping them. For example, when guiding a person to a seat or assisting a person with their meals. We saw that people could be independent such as going out into the garden or mobilising around the service using walking aids. During our inspection, people's visitors were seen coming and going from the service. Relatives we spoke with told us that they were always warmly welcomed by the staff at any time of the day.

Good

Is the service responsive?

Our findings

The service remains good because people continued to receive support and care that was responsive to their needs. People's needs were assessed prior to them moving into the service to ensure their requirements could be met. People and their families were involved in the development of care records. Care records contained life and social history information so that staff could get to know the people they supported. Staff completed daily notes, as a record of how people had spent their day meaningfully. These records as well as the handover at the start of each shift, provided staff coming on duty with an overview of any changes in people's needs and their general well-being.

The number and variety of activities provided at the service for people to take part in should they wish had improved following feedback from people. Most people and their relatives, had very positive opinions about the activities provided. One relative told us, "There are many close links with the local community and this is growing. We have links with the village magazine, we had a fete here and it was really well supported. Outreach from the community is very strong [named service] have a good service for transport, we can use their mini buses or cars to take residents on trips. ….Indoor activities are very varied. We have good quality entertainers coming in." However, one person said, "I get frustrated when I talk to [people in the service] or they do simple quizzes, so I don't participate in many of the activities." The registered manager told us, and meeting minutes showed, that this had already been identified as an area of improvement. The new role of social facilitator within the service was aimed at helping stimulate people who liked activities that were more intellectually stimulating.

Compliments had been received about the care provided by staff at the service provided since our last inspection. The service had a complaints process in place that was easy and accessible for people to use. People and their relatives spoken with told us that they felt comfortable about raising a complaint or making suggestions if they needed to. Complaints had been received since the last inspection. Records showed, no obvious themes and the complaints were handled effectively in line with the providers complaints policy and resolved where possible to the complainants' satisfaction.

Where people had been prepared to discuss their future wishes in the event of deteriorating health, these wishes had been clearly identified in their care records. The information included how and where they wished to be cared for and any arrangements to be made following their death. We saw that Do Not Attempt Resuscitation (DNAR) forms were in place for people who had chosen not to be resuscitated. This helped to make sure staff knew about people's wishes in advance. Staff had taken part in end-of-life learning sets and specific end-of-life training was being implemented to help build on this knowledge. The registered manager told us that they worked with external health care professionals' guidance and advice when it became clear that people's health conditions had deteriorated. This enabled staff to support people to have the most comfortable, dignified, and pain-free a death as possible.

Good

Is the service well-led?

Our findings

The service remained good because it was managed well. There continued to be registered manager at the service. 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. They were supported day-to-day by care staff and ancillary staff.

The registered manager and staff showed a good knowledge of people's care and support needs. Staff were clear about the expectation to provide a good quality service that met and supported people's individual needs. The registered manager and staff promoted equality and inclusion within its service and workforce. A staff member said, "We are all individual, we all have different beliefs and ways and we should respect one another." Staff told us that they felt supported by the registered manager who they said was approachable, listened to them and where possible implemented their suggestions. For example, this included splitting people who live at the service into two smaller groups for meetings. This staff said, would help them to have time to encourage and support people to communicate their suggestions.

People and their relatives were complimentary about the service provided, and how the service was run. Relatives told us that they could speak to the registered manager should they wish to do so and that the registered manager made themselves available for this. Records showed that a 'resident, relatives and staff' survey had been carried out since the last inspection to gain feedback on the quality of the service provided. Initial feedback was positive but it was too soon for the results to be analysed in full and any actions determined and implemented.

The registered manager of the service made checks to monitor the quality and safety of the service provided. There was organisational oversight and systems in place to ensure checks and audits were carried out and followed through to drive improvement. For any areas of improvement found, actions were taken to reduce the risk of recurrence. For example, additional staff training being sought to develop their skills and knowledge. This showed us that the service looked to continuously improve the quality of service provided.

Records the Care Quality Commission (CQC) held about the service and looked at during the inspection, confirmed that the provider had sent notifications to the CQC as legally required. A notification is information about important events that the provider is required by law to notify us about such as safeguarding concerns, deaths, and serious incidents. In addition, the provider was correctly displaying their previous inspection rating conspicuously.

Staff at the service worked in partnership and shared information with other key organisations and agencies to provide joined up care for people using the service. This included working with a variety of health and social care providers. A health practitioner told us, "I found [staff] would act on advice and would not hesitate to contact my team if they were unsure about anything or wanted to discuss concerns."