Madeira Care Home Limited

Madeira House

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

What life is like for people using this service:

Systems and processes were in place to safeguarded people from the risk of abuse. People had their risk of harm assessed and reviewed. There were sufficient numbers of staff on duty to look after people. People received their medicine from staff who were competent to do so. The service was clean. Lessons were learnt when things went wrong.

Staff delivered care in line with national guidance. Staff are supported to develop and maintain their knowledge and skills. People are provided with a nutritious, varied and balanced diet. People are enabled to access their GP, dentist and optician. All areas of the service are accessible. People's rights were maintained under the Mental Capacity Act 2005.

People were looked after by kind, caring and compassionate staff. People were enabled to have a say in their care and the running of the service. Staff treated people with dignity and respect.

People received person centred care. Staff enabled people to maintain their hobbies, interests and pastimes. There were systems in place to manage complaints. People at the end of their life were supported to have a dignified and pain free death.

The manager is an approachable and visible leader. The manager and their team were committed to improving the quality and standards of care people received. Links are being built with the local community and partner agencies. There is a good governance framework, leading to improvements in the service.

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

Rating at last inspection: Good (report published 01 February 2016)

About the service: Madeira House is a residential care home for up to 51 older people or people living with dementia, a sensory impairment or a physical disability. On the day of our inspection 35 people lived there.

Why we inspected: This was a planned inspection based on the rating at the last inspection. The service remained rated Good overall.

Follow up: We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received we may inspect sooner.

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 was safe Details are in our Safe findings below.	**Good**
Is the service effective? The service was effective Details are in our Effective findings below.	**Good**
Is the service caring? The service was caring Details are in our Caring findings below.	**Good**
Is the service responsive? The service was responsive Details are in our Responsive findings below.	**Good**
Is the service well-led? The service was well-led Details are in our Well-Led findings below.	**Good**

Madeira House

Detailed findings

Background to this inspection

The 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.

Inspection team: The inspection team was made up of two inspectors.

Service and service type: Madeira House is a care home. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have manager registered with the Care Quality Commission at the time of our inspection. The manager's application was being processed by CQC and was authorised in November 2018. 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: The inspection was unannounced.

What we did:
We reviewed information we had received about the service since the last inspection. This included details about incidents the provider must notify us about, such as poor practice concerns; and we sought feedback from the local authority and other professionals who work with the service. We assessed the 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. We used all this information to plan our inspection.

During the inspection we spoke with seven people and three relatives to ask about their experience of the care provided. 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 talk with us.

We spoke with ten members of staff including the registered manager, the head housekeeper, the cook and three members of care staff.

We reviewed a range of records. This included five people's care records and two medication records. We also looked at three staff files around staff recruitment. In addition, we looked at various records in relation to training and supervision of staff, records relating to the management of the home and a variety of policies and procedures developed and implemented by the provider.

Good

Is the service safe?

Our findings

Safe – this means people were protected from abuse and avoidable harm

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

Systems and processes
● There were effective safeguarding systems and processes in place to protect people from abuse and harm.

Assessing risk, safety monitoring and management
● People had their risk of harm assessed on admission and identified risks were regularly reviewed.
• At each shift handover a member of staff from each shift signed a handover sheet to confirm that safety checks have been carried out. These safety checks included fire exits, call buzzers and hoists.
• We saw up to date records were kept on the maintenance of fire safety and utility systems such as electrical items and gas appliances.
• There was at least one designated fire marshal on duty each shift. People who lived in the service had a personal emergency evacuation plan (PEEP) in place. This provided staff with information on how to safely evacuate the person to a place of safety in an emergency.

Staffing levels
● There were sufficient numbers of staff on duty to support people and keep them safe.
• A robust recruitment and selection process was in place and staff had been subject to criminal record checks before starting work at the service. These checks are carried out by the Disclosure and Barring Service (DBS) and helps employers to make safer recruitment decisions and prevent unsuitable staff being employed.
• We observed that when a person used their call buzzer to request assistance that staff responded promptly.

Using medicines safely
• Robust systems were in place for the safe ordering, storage, administration and disposal of medicines. The medicine policy adhered to up to date national guidance for the safe management of medicines in care homes.
• We found that people's medicines, including controlled drugs were managed consistently and safely by staff who were assessed as competent to do so.
• The provider had subscribed to an electronic medicine administration record (MAR) in partnership with their dispensing pharmacist. This helped to reduce the risk of errors as the system flagged when a medicine had not been given and also when it was due.
• Another safety function of the electronic system was that any changes made to a person's medicines by their GP was automatically updated on the system by the pharmacist. This reduced the risk of transcribing errors.
• We looked at the MAR for four people and found that medicines had been given consistently and there were no gaps in the MAR. Each record had a photograph of the person for identification purposes and any

allergies and special instructions on how to administer individual medicines were recorded.
• Some people were prescribed as required medicine, such as pain relief, and staff had access to protocols to enable them to administer the medicine safely.

Preventing and controlling infection
● People were cared for in a clean environment and there were no offensive odours.
• The laundry was a good example of dirty and clean flow-through system. There was ample space to minimise the risk of cross contamination.
• Housekeeping staff adhered to detailed cleaning schedules for all areas of the service and cleaning tasks were signed off when completed.
• Risk assessments had been carried out for the safe use and storage of detergents and the provider followed the Control of Substances Hazardous to Health Standards (COSHH). The cleaning products had recently changed and staff were being trained on how to safely handle the new detergents.
• Staff used personal protective clothing, such as gloves and aprons when assisting people with their personal care, handling soiled laundry or disposing of clinical waste.
• The home had been awarded a five-star rating from the food standards agency. This is the top rating and shows appropriate systems were in place to ensure good hygiene levels.
• A new twilight housekeeping shift had been introduced a few weeks before our inspection. The initial feedback was positive as public areas had flooring and arm chairs deep cleaned without disturbing the people who lived in the service.

Learning lessons when things go wrong
● We found evidence that lessons were learnt when things went wrong.
• Incidents were recorded, fully investigated and actions were taken to resolve. When appropriate, lessons learnt were shared with all staff.

Good

Is the service effective?

Our findings

Effective – this means 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 had their care needs assessed and care, treatment and support were delivered in line with national guidance.

Staff skills, knowledge and experience
• People were cared for by staff who were enabled to develop their knowledge, skills and experience. Staff attended mandatory training such as fire safety and safe moving and handling. In addition, they were provided with training pertinent to their roles and individual needs of the people in their care.For example, a senior member of care staff told us that they had recently attended training to help them understand the needs of a person living with dementia and said,
• Some staff had lead roles relevant to their area of interest. For example, the head housekeeper was the infection, prevention and control lead and was supported by the local authority as an infection prevention and control ambassadors. They attended regular meetings and were kept up to date with best practice national guidance. Their new-found knowledge was shared with colleagues.
● We found that newly appointed staff were enabled to undertake the Care Certificate, a 12-week national programme that covered all aspects of health and social care.
• All staff received regular supervision sessions from the registered manager or a senior member of nursing or care staff. The sessions were focussed on the needs of the people who lived at the service and were supported by national guidance. For example, recent sessions included the principles of the mental capacity act and effective hand washing. We saw that records were maintained and areas for improvement and professional development were identified. Staff also received an annual appraisal on their performance, career aspirations and professional development from the manager. Staff were also invited to give their feedback on their experience of working at the service through an annual satisfaction survey.

Supporting people to eat and drink enough with choice in a balanced diet
● We received positive comments about the quality of the meals provided. One person said, "The food is good, brilliant cook. We get a choice every day." One person's relative told us, "There is a new cook. I'm full of praise."
• People were provided with a nutritious, varied and balanced diet. Snacks including fresh fruit were available throughout the day and people, where able could help themselves.
• At lunchtime, people were offered a choice. The chef was present in the dining-room and asked people if they enjoyed their meal. One person had a second helping of the main course and told us how much they enjoyed the food.
• We observed the chef sit down and talk with a person about their special dietary needs to ensure that they received their favoured meals.

Staff providing consistent, effective, timely care

● Care staff shared information at shift handovers about individual care needs and overall wellbeing to maintain continuity of care. GP appointments and district nurse visits were recorded in a diary.

Adapting service, design, decoration to meet people's needs

● We saw that some areas of the environment were designed to promote independence and wellbeing with people who may become disorientated or forgetful. For example, bedroom doors were painted in different colours and with the room number prominent, like a front door in a house. Most people had a memory box at their 'front door' with items of memorabilia pertinent to them. This helped people identify their personal space.

• Information on activities in the service was visible in both picture and word format to raise awareness of the pastimes people could join in. In addition, the daily menus were written on a large chalkboard in the dining room.

• Some areas of the service looked tired and would benefit from refurbishment and decoration. The manager told us that decoration of the premises was ongoing.

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 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

• Prior to our inspection we requested and received information from the local authority mental capacity team about the number of current DoLS authorisations granted to people living in the service. Twelve people were currently being lawfully deprived of their liberty

● Staff understood the principles of MCA and sought consent from people for aspects of their care. For example, when a person was admitted to the service as an emergency social admission staff obtained their consent to live in the service. Where a person had appointed a lasting Power of Attorney (LPA) to act on their behalf when they were no longer able to make decisions for themselves a copy was kept with the person's care file.

• When a major decision, such as permanently moving into the service had to made, a best interest meeting was undertaken with the person and their family or representative. This recorded that staff were acting in the person's best interest.

Good

Is the service caring?

Our findings

Caring – this means 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
• We observed that people were cared for by kind, caring and compassionate staff from all disciplines. There was friendly banter between people and staff and we could see that they were at ease with each other. Staff were always smiling and people responded in kind. A member of staff entered the lounge and started to sing a song. People quickly joined in and an impromptu sing-song was soon in full swing. People were clapping their hands and looked happy.
• We received many positive comments from people and their relatives about how they were treated and supported. These comments reflected our observations. One person's relative said, "Absolutely fantastic staff. They have a good set up. I have praise for everything. [Name of person] is so happy." Another person told us, "The staff are very kind. It is a good place to live. They bring me fruit if I ask for it."

Supporting people to express their views and be involved in making decisions about their care
●People were supported to complete a document called "This is me." This gave staff valuable insight into the person's background and history; their likes and dislikes and the little things that made them unique.
• People told us that staff frequently asked them for their feedback on the care they received. One person said, "They always ask me if I'm okay and have a chat with me."
• We found that people had a voice and were listened to by staff and management. The dining room was recently decorated and people had been provided with samples of window blinds and table cloths to choose from. A member of staff told us why it was important that people were involved in the decoration of the service and said, "It's their home, they live here."
• We spoke with the Head of Quality for the provider organisation who shared with us how they obtained the views of people who lived at the service, their relatives and friends through an annual quality assurance survey and food satisfaction survey.

Respecting and promoting people's privacy, dignity and independence
● We saw that staff respected the individual person's privacy and dignity and promoted their independence.
• People told us that staff treated them with dignity and respect and made them feel like they mattered. One person said, "They [care staff] don't talk to you like an idiot."
• Staff treated people with dignity and respect. We saw when staff spoke with a person that they sat down beside them, made eye contact and held their hand. Staff shared with us how the maintained a person's dignity when providing personal care. One staff member said, "We talk to people about what they want. We respect their privacy and dignity and shut doors. I talk them through what I am doing or about to do. I put them first and always make sure they are okay."
• We saw that care records and personal files were stored securely and all computers were password protected. This meant that their confidential information was stored in compliance with the Data Protection

Act and the General Data Protection Regulations (GDPR).
• Family and friends were welcome to visit anytime apart from mealtimes. This was to reduce the risk of people being disturbed and to encourage a positive dining experience. Furthermore, people were encouraged to take trips out with family. One person who lived locally, returned home most days to have lunch with their spouse and told us, "When we return in the evening [name of spouse] has tea [evening meal] with me."
• People were encouraged and enabled to personalise their bedrooms with familiar items from home, such as family photographs, ornaments and soft furnishings.
• We saw that the laundry staff paid attention to detail. Personal clothing was washed, dried, ironed and put away neatly.
• The service had a designated dignity champion, who was responsible for sharing current best practice guidance to their colleagues. The dignity champion told us that they would challenge undignified care and said, "I'm not scared to pick up faults in a nice way. We [staff] treat each other with respect also."

Good

Is the service responsive?

Our findings

Responsive – this means that services met people's needs

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

Personalised care

• People had their care needs assessed and personalised care plans were introduced to outline the care they received. Care was person centred and people and their relatives were involved in planning their care. We saw that individual care plans focussed on supporting a people to live well and maintain their optimum level of independence and well-being.
• People and their relatives told us that the manager and staff understood their needs. One person explained what this meant to them and said, "[Manager] really understands my condition. She really has a heart of gold. It means so much to me."
• We saw that care files were well organised and easy to use.
• The service had taken steps to meet the Accessible Information Standard (AIS). All providers of NHS care or other publicly-funded adult social care must meet the AIS. This applies to people who use a service and have information or communication needs because of a disability, impairment or sensory loss.
• We noted that one person with a hearing impairment did not like to wear their hearing aids. Their care plan clearly recorded their communication needs and their preference to lip read.
• Staff told us pow they communicated with people who were unable to express their needs verbally. One staff member said, "If someone can't communicate verbally we look for facial recognition."
● We found that care was focussed on the person and there was no evidence of ritualistic routines or task orientated care. Staff acknowledged people as unique individuals. For example, we spoke with one person who had dexterity problems and was therefore unable to use their call buzzer. They told us that they had a sensor mat at the side of their bed that they stood on when they required assistance from care staff.
• People were supported to maintain their hobbies and interests and enabled to develop new ones. For example, we observed a friendship group in the lounge, enjoying each other's company as they followed their own interests. One person was knitting, one sewing and another was painting.
• In contrast to the individual activities, we observed six people in the conservatory baking jam tarts with the activity coordinators. Each person had their own baking bowl, utensils and ingredients. We noted that people chatted freely with each other and there was much laughter. They told us that it was 'National Baking Week' and were looking forward to the following Sunday as it was cake decoration day.
• The activity coordinator maintained accurate records of individual histories, likes and dislikes and ensured that people were supported in their preferred activities and pastimes to ensure that they were not excluded.
• People were also enabled and supported to participate and become involved with external groups and organisations, such as The Rotary Club, The Women's Institute, The Bee Keepers Association and engaging with local school children.
• We saw that staff and people who lived in the service respected peoples' religious and spiritual beliefs and supported them to follow the faith of their choice. For example, a communion service was held once a

month. Staff had received training in equality and diversity and understood how to use this knowledge to reduce any possible barriers to care.

Improving care quality in response to complaints or concerns

● Information on how to make a complaint was prominently displayed on a poster at the main entrance. Complaint leaflets were also available and people could read these in the privacy of their own bedroom.

• We noted that complaints made about the service were fully investigated and a letter of the outcome was sent to the complainant. Where a staff member was involved, they were supported to give a formal apology.

• People and their relatives told us that if they had a problem that they would feel confident discussing their concerns with the manager.

End of life care and support

● People had their end of life care wishes recorded in a care plan. Staff were aware of how to promote a dignified death. One member of staff said, "We treat the person with the same level of dignity and respect. Even although we think they might not be able hear, we still talk to them. We make sure they are clean and comfortable. I hold their hand and read to them." They also explained how they supported relatives as it was a difficult time for them.

• Some people had a made the decision not to be resuscitated if their heart was to suddenly stop beating. We saw that the proper documentation had been completed by a competent healthcare professional, such as their GP.

Good

Is the service well-led?

Our findings

Well-Led – this means 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.

Leadership and management

Provider plans and promotes person-centred, high-quality care and support, and understands and acts on duty of candour responsibility when things go wrong

●The provider promoted a positive culture where staff were supported, respected and valued by management and each other. We noted than when this positive culture had not been upheld that the provider took appropriate action to ensure fairness and respect for all staff.

• We observed that in the short time the manager was in post that they knew people well. They had a good rapport with people and we found evidence of mutual respect. One person and their relative spoke highly of the manager and the positive impact they had on the service in a short space of time.

Managers and staff are clear about their roles, and understand quality performance, risks and regulatory requirements

● The manager had recently been appointed to the service and was in the process of submitting their application to be registered with CQC. They were registered with CQC in November 2018.

• We spoke with heads of department who were enthusiastic and passionate about their roles and responsibilities. We observed that the senior team were visible role models to other staff.

• The manager and provider had submitted notifications that they are required by law to submit to CQC.

• It is a statutory requirement that a provider's latest CQC inspection report is clearly displayed at the service and on their website. This is so that people who lived in the service and those seeking information about the service can be informed of our judgments. The rating from the previous inspection was displayed in the main reception area and on their website

• The provider regularly acknowledged individual members of staff for their achievements and commitment to their role. We saw that a member of staff had received a certificate and financial award for going above and beyond the call of duty. This formal recognition acted as an incentive for other staff to give their best. Staff told us that it made them feel valued.

Engaging and involving people using the service, the public and staff

●The recently appointed manager explained that the service had been without a registered manager for several months and staff had reported that they had found this period unsettling. In response to this, the manager had introduced regular weekly staff meetings to ensure staff were up to date with all aspects of the service and organisation.

• We received positive feedback from staff about the steps the manager had taken to engage with them. One staff member said, "We have staff meetings, [name of manager] has set their vision and we are working as a

team, she is a breath of fresh air. She is approachable, listens to our ideas and down to earth."
• We looked at the minutes of the staff meeting held on 4 October 2018 and noted that staff had a voice, gave their feedback on the service and made suggestions for improvements to the service.
• People, their relatives and staff were provided with a monthly newsletter. We noted that the September issue had a review of events from the previous months and 'dates for your diary' for the current month.
• People and their relatives were invited to attend regular meeting with the manager and key staff. The last one was held in August 2018 and the next one was planned for November 2018. This enabled the manager to provide updates on the service and for people and their relatives to share their experience on the service and make suggestions for change.
• People confirmed that they attended meetings and had a say in the running of the service. One person said, "We have a meeting where we can talk about things going on here and make suggestions. [Manager] makes sure that things happen."

Involvement improving through regular meetings and newsletters.
• There was an accessible suggestion box that people and their relatives and friends used to share their thoughts on improvements to the service. We noted that one person had requested '60's music' and this had been provided.

Continuous learning and improving care
● We found that the manager and their team are committed to improving the standards of care and sustaining these improvements.
• There were robust quality monitoring and clinical governance systems and processes in place. We looked at a range of audits that measured the standards and quality of the care people received. Once a year a mock regulatory inspection was carried out by the provider. This looked at all the Key Lines of Enquiry (KLOES) that CQC inspect against and provided the manager with an insight into areas that required improvement.
• The manager had support from the head of quality and compliance and a regional quality manager to help analyse the outcomes from the audits and introduced compliance actions.
• All audits and analysis reports were shared at regional governance meetings and with the executive board. Registered managers learnt from each other through regular meetings. The manager told us that lessons were learnt from other registered managers' experiences. In addition, they received a monthly newsletter called, "Quality Matters". This provided registered managers with feedback on all quality issues raised in the organisation in the previous month.
• The manager delegated responsibilities to their heads of department and enabled them to develop their leadership skills. For example, we noted that the head housekeeper was empowered to lead their team. They told us, "I have been recently promoted and have been supported by [Manager] to put structure into the department; I do the rotas, allocate tasks and develop standards." We found that they were responsible for undertaking the infection control and mattress audits and feedback to the manager once a month.

Working in partnership with others
● The manager demonstrated that they are building positive working relationships with partner agencies such as the local authority and the clinical commissioning group. The lead activity coordinator was working with community groups and people had shared activities and visits to a dementia group. They told us, "I'm marketing Madeira House, to spread the word in the community. The service was also a member of several national and local organisations that helped them to deliver good practice. These include National Activities Providers Association (NAPA).