

South West Care Homes Limited

Cambrian Lodge

Inspection report

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Ratings

Overall rating for this service

Requires improvement



Is the service safe?

Requires improvement



Is the service effective?

Good



Is the service caring?

Requires improvement



Is the service responsive?

Good



Is the service well-led?

Requires improvement



Overall summary

This inspection took place on the 5 and the 9 February 2015 and was unannounced.

Cambrian Lodge provides accommodation and personal care for up to 28 older people. Some people living at the home were living with dementia which means their ability to understand and communicate their needs and wishes was limited. Most people were dependent on the staff to meet all of their care needs. At the time of our inspection there were 20 people living at the home.

Cambrian Lodge is large converted villa in a residential area of Portishead. The accommodation is over 4 floors which is accessed via two lifts and a staircases.

A registered manager was in post. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Summary of findings

At the last inspection carried out on the 17th and 18th July 2014 we found the provider was not meeting the regulation in relation to consent to care and treatment, care and welfare, infection control, assessment and monitoring the quality of the service and records. Following that inspection the provider sent us an action plan telling us what improvements they were going to make. During this inspection we found that the provider had made positive steps towards achieving their action plan but there were still some areas of concern relating to poor practice in the administration of medicines.

The management of medicines was not always being delivered in a safe manner. This practice on the day of our inspection was putting people at risk of not having medicines as required whilst also having access to medicine that was not intended for their use. We informed the registered manager of this practice.

On this inspection we found staff were undertaking appropriate best practice to manage infection control within the service. Previous areas relating to shortfalls had been actioned. The service at the time of our inspection had failed to undertake a current risk assessment relating to a current infection control procedure. This was sent through immediately after the inspection.

People who required support and assistance at night were receiving appropriate care and support they needed from staff. We found on the day of our inspection there were adequate staffing levels to meet people's needs. .

Risk assessments were in place and identified where people were at risk of dehydration and malnutrition. The food and fluid charts confirmed what amounts people had consumed these had all been signed.

Care plans identified people's mobility needs and risk assessments included details of what equipment the person required and how many staff. People and relatives told us they felt people were safe. There were policies and procedures in place which were available for staff. Training had been provided to the staff but on talking to some staff they were unable to clearly give a good account of their knowledge after receiving safeguarding training.

The service had robust recruitment and selection processes in place and we saw appropriate paperwork for all staff.

The home was undertaking when required all assessments in relation to The Mental Capacity Act and Deprivation of Liberty Safeguards. We found not all staff were able to demonstrate clearly their knowledge relating to the Act. It was also hard to establish they were competent and knowledgeable about the training they had undertaken.

The home had a variety of choices relating to meals and people we spoke with were all happy with the meals and choice within the home. We saw there were snacks available throughout the day.

We found that not all people received respectful and positive interactions from staff. People told us staff were kind and considerate but we did not always see this was the case.

Care plans related to most people's changing needs. But one had not been updated following an incident and a change to their current need. There were a variety of activities and there was a weekly activity programme. People chose to access areas of the home as they wished throughout the day.

We found people felt aware of how to complain and confident that they could do so. We saw that were the service had received complaints that these had been responded to and actions taken.

The home was not undertaking robust quality audits that identified areas of concern in relation to building's maintenance, health and safety and infection control. Concerns we found have since been addressed. However we require the home to have their own robust quality audits that identify shortfalls and for there to be a plan regarding completion of those shortfalls.

Staff felt well supported by the manager and that there was an open door policy. People and relatives were complimentary about the manager and deputy and said they had a good relationship with them. The service was gaining views from people who received care within Cambrian Lodge but there was only the compliments and complaints box in situ for staff and relatives to use. There was a system for recording incidents and accidents and there was a monthly analysis conducted and a log of what actions had been taken.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

This service was not ensuring people were safe.

The home was not always administering and recording medicines in line with safe practice guidelines. This meant at times people were being put at risk due to the incorrect handling and recording of their medicines.

People and relatives that we spoke with all felt safe living at the home.

People and visitors at times felt that there were not enough staff on duty when the home was busy. We found on the two days of our inspection people had their needs met and call bells answered in a timely manner.

Requires improvement



Is the service effective?

The service was effective.

Staff had received mandatory training but were unable to clearly evidence they had a satisfactory standard of competency after attending this training.

People were supported to access health care professionals when required and in a timely manner.

The service was undertaking assessments and best interest decisions as required by The Mental Capacity Act.

Good



Is the service caring?

The service was not always caring.

This was because not all people were spoken to in a polite and respectful manner.

People told us that staff were kind and considerate and we observed staff knock before they entered people's rooms.

Care plans contained personal information such as their likes and dislikes.

Care plans were reviewed monthly and we saw people and their family members were being involved within this process.

Requires improvement



Is the service responsive?

The service was responsive.

We found most care plans reflected peoples changing needs apart from one person who was now receiving different support in relation to their personal care routine.

Care plans accurately reflected changes to peoples skin and recorded equipment and the support they required.

Good



Summary of findings

People and relatives felt able to make a complaint should the need arise. We saw complaints were dealt with and action taken as required.

Is the service well-led?

We found the service was not well led.

The home did not have robust audits in place to ensure all shortfalls in relation to infection control and buildings maintenance were in place.

The service had sent out a customer satisfaction survey in August 2015. Areas of improvement were identified and actions were taken. There was a system for staff and relatives to make comments on the service.

Requires improvement



Cambrian Lodge

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 associate with the Health and Social Care Act 2008, and to provide a rating for the service under the Care Act 2014.

This was an unannounced inspection which took place over two days on 5 and 9 February 2015. On the first day the team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day the lead inspector was accompanied by a second inspector.

Before the inspection, we reviewed all information we held about the service including previous inspection reports and notifications received by the Care Quality Commission. A Notification is where the registered manager tells us about

important issues and events which have happened at the service. Before the inspection, the provider was asked to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. They did not return a PIR and we took this into account when we made the judgements in this report.

We spoke with ten of the 20 people living at Cambrian Lodge and seven visiting relatives. We gained their views on all aspects of their experience at Cambrian Lodge. We also spoke with the registered manager, deputy manager, the team leader, the chef, five care staff, one district nurse, one chiropodist and one external support worker. We looked at seven people's care records and documentation in relation to the management of the home. This included staff supervision, training and recruitment records, quality auditing, policies and procedures. We looked around the premises, observed care practices and the administration of medicines.

Is the service safe?

Our findings

We found that the administration of medicines was not always being safely provided or accurately recorded. This was because on the first day of our inspection one member of staff was administering and recording medicine as taken when in fact the medicine had been left for the people to take at a later date. We spoke with the member of staff about this practice they confirmed this was their normal procedure. We fed this practice back to the registered manager who was going to address our concerns raised.

Medicines were stored securely. We reviewed the recording of the temperatures for all fridges where medicines were stored. We found some entry's fluctuated between the recommended five degrees. This meant medication could be at risk of not being kept at the required optimum temperature. We observed one fridge in a very warm room fluctuated between temperatures. We fed this back to the registered manager who was going to see if there was an alternative area this fridge could be kept. The home had put new systems in place after medication had gone missing. Medicine stock was being accurately checked and recorded after every shift. Since implementing this system there had been no more missing medicines.

At our last inspection in July 2014 we found areas of concern with the Infection control standards and laundry facilities. We found laundry was not being stored correctly and that contaminated and soiled laundry was not being processed according to the guidance from the Department of Health code of practice. Storage areas which contained clean laundered clothes had exposed walls covered in flaking peeling paint.

On this inspection we reviewed the standard of infection control within the home. We found a newly decorated storage area where clean sheets and bedding were being appropriately stored. There was a new laundry trolley which ensured that dirty and contaminated laundry was kept off the floor whilst waiting to be washed. We spoke with one member of staff who confirmed the process for washing people's clothes. They told us "all clothing is now washed in the red disposable bags". They were unable to explain the reason why all laundry should be washed like this as only contaminated laundry should go through this process. The registered manager confirmed it was due to current infection control procedures they had in place. We requested a copy of the risk assessment relating to this

infection control process. There was not one in place. Since this inspection we have received a risk assessment covering risks of infected laundry. All staff should have a clear understanding of requirements relating to washing laundry that is dirty or contaminated.

We reviewed other areas of infection control throughout the home. Previously we found that soap and hand towels were not available at the point of care. At this inspection we found action had been taken so staff had access to soap and hand towels. We found not all bathrooms and toilets had access to a clinical waste bin. We discussed this with the registered manager. They immediately ordered yellow peddle bins for those areas without a clinical bin. Staff had received training in relation to infection control.

At our last inspection in July 2014 we found two people were not receiving the care and support they required during the night. Due to time sheets submitted and the sleeping arrangements of the night staff. On this inspection we found only one person required care and support during the night. We reviewed their assessments, care plan and staffs timesheets. We found support they required over night was clearly recorded as being provided.

We spoke with people and visitors. They felt at times there could be more staff on duty. They told us, "Residents are left alone if there is an emergency elsewhere", "It is sometimes frustrating not being able to get information, as they are so busy I don't like to ask", "They may be short of staff but my relative is always clean and well dressed, what they lack is someone who has time to just sit and chat with them". Staff we spoke with told us they felt staffing levels were adequate. We spoke with the manager about the staffing levels, they showed us the rota. This confirmed four care staff were on duty throughout the day with two staff at night. At night one member of staff was awake and one who was woken when support was required. Staff we spoke with told us that all shifts were adequately covered. On the day of our inspection we found people did not have to wait for support and we heard call bells were answered in a timely manner.

At our last inspection in July 2014 we found people were at risk of receiving care and treatment that was inadequate or poor due to poor record keeping. This was due to charts relating to food, fluid intake and repositioning were not being accurately filled in. On this inspection we found an improvement to the records although we found some areas the service could still be improved. We reviewed two

Is the service safe?

people who were at risk of pressure ulcerations. Both had new assessments which identified the area at risk and the support they required. One person was having regular visits from the district nursing team who were actively monitoring the area of risk. The other person had a turning chart in situ. We reviewed the completion of this chart. We found that not all entries had been accurately recorded. Some entries were recorded on the wrong day for example when the support was provided overnight and into the next day a new chart should have been started. The person required to be turned every two hours during the day and three hourly at night. We reviewed three days of turning charts. All but one entry showed the person had been repositioned at the required times.

We saw one person who was at risk of dehydration and malnutrition. Risk assessments were in place which identified the risks and how to minimise them. There was also a food summary in place confirming what the person liked to eat. We saw the food and fluid charts confirmed what amounts had been consumed, the time and all entries had been signed by the member of staff. This meant this person had their needs met in relation to their eating and drinking.

We reviewed four care plans in relation to the person's mobility needs. We found all assessments included current details of what equipment the person required and how many staff. These assessments also identified to staff the level of risk associated with that activity. All four care plans also had individual risk assessments relating to radiators and hot water within that person's room.

People we spoke with said they felt safe living at the home. They told us, "There's nothing to worry about, I have never felt unsafe", "I came here because my family were worried about my safety, now everyone is happy because I am safe", and "for the first time in my life I feel safe, I am with honest people". One relative felt the home and people were safe. They told us "yes people are safe the building needs some work but it's an old building".

The provider had whistleblowing and safeguarding policies and procedures in place, which were available for staff. We looked at training records which confirmed that staff had completed their safeguarding adults training. Not all staff we spoke with were aware of the policies. One member of staff confirmed they would immediately raise any concerns with the manager and they were confident that appropriate actions would be taken. Other staff were unable to give a clear understanding of the two policies or what actions they would take. We asked the registered manager what system they had in place to ensure staff were competent after their training. There was no current system in place to ensure staff had the skills and knowledge after they had received training. The manager was responsible for making safeguarding referrals. We saw evidence they were making safeguarding referrals when reviewed to other professional bodies and to us.

There were robust recruitment and selection processes in place. This minimised the risk of people being supported by unsuitable staff. We looked at four personnel files that demonstrated appropriate checks had been carried out before new members of staff worked with people. There was appropriate paperwork in place for those staff who previously lived outside of the United Kingdom. All files that we reviewed had paperwork relating to a completed probation review.

There was a disciplinary procedure in place. We saw the registered manager took action when required through this process.

We reviewed the personal evacuation plans for four people within the home. These plans identified what level of support people required, the equipment and how many staff. They had all been reviewed in the last few months. This meant that information was up to date and available to staff should they need to undertake an emergency evacuation.

Is the service effective?

Our findings

At our last inspection in July 2014 we found the home was failing to undertake Mental Capacity Assessments and document best interest decisions involving family, relatives and significant others. On this inspection we found action had been taken to undertake Mental Capacity Assessments and best interest decisions when required. The registered manager understood the requirements of the Deprivation of Liberty Safeguards (DoLS) and had systems in place to follow the procedures when required. Staff had received training in the Mental Capacity Act (MCA) and DoLS. We spoke with staff about their knowledge. Only some staff were able to demonstrate clearly their knowledge relating to the Act. We found the service was following the MCA code of practice and made sure the human rights of people were protected.

We reviewed the skills and knowledge of staff within the home. Staff had completed an induction before working for the service which included agency staff. This was confirmed in staff training records. We found on talking to staff it was hard to establish they were competent and knowledgeable about the training they had undertaken. We spoke with three staff who had just completed their induction process. We asked them to explain what training they had undertaken and how they had found it. All three staff were unable to give a clear account of the training they had received or the knowledge that they had after attending this training. We raised these concerns with the manager.

Staff we spoke with told us they were provided with good support from the registered manager. Comments included, "I have a sit down supervisions session and observed practice about 2 or 3 times a year, they are always available and very approachable". Supervision was held with staff regularly and we saw evidence that a number of staff had received supervision in recent months

The registered manager was attempting to make the home environment more dementia friendly. Communal areas had been painted brightly with colour changes to indicate different areas. New carpets and bright armchairs had been

ordered to replace the existing ones in the large front sitting room. There were items of memorabilia, craft materials, jigsaw puzzles and games available which were stored in this room.

One person told us, "If I need to see my doctor, staff would arrange for them to come and see me". People's care records showed referrals had been made to appropriate health professionals when required. When a person had not been well, we saw that the relevant healthcare professional had been contacted to review their condition.

People told us that food and drink was available throughout the day. One person told us, "The food is very nice and we have drinks and snacks during the day and there is fruit if I want some" and "The meals are good, plenty of refreshments and snacks or fruit are around for me to have if I'm hungry". We saw people were provided with a choice of nutritious food. The cook told us that people had two choices every day. They showed us the list of what people had chosen the day before. Where one person had a special diet this was identified and recorded on the list and within their care plan.

We found people were assessed to determine whether they were at risk of malnutrition and where risks were identified care plans were put in place to assist staff in meeting these needs. People's weight was being monitored and we saw evidence of involvement of dieticians where weight loss was identified. We observed lunch being served to people in the home and saw people who required support with eating their meal were assisted by staff in a discreet and unhurried manner.

One relative that we spoke with felt that there was good contact with professionals and that they could not fault the contact the home had with the medical professionals relating to their relatives health needs. The chiropodist that we spoke with confirmed there was good communication with the home and the manager. The home had a good working partnership with the local district nursing team, GP surgery, chiropodist and the falls team. There was regular contact with these professionals and we saw notes that confirmed their visits. The district nurse we spoke with felt happy with the contact made by the service to them and the local GP practice.

Is the service caring?

Our findings

We spoke with three people who told us staff were kind and considerate. People said their independence was promoted and privacy and dignity was respected. Comments included, “Staff are good, they know what to do if I have pain”, “Staff are very good, it is no use being proud you have to accept help”.

We observed staff interactions with people within the home. We found that not all staff spoke with people in a respectful and appropriate manner. For example we observed one member of staff who spoke to a person in an abrupt manner, whilst they walked away from them. The person who was visually impaired was left unsure if the member of staff was still talking to them or if they were still within close proximity. We also found they failed to explain exactly what they were doing. This created a negative response from the person who verbalised their dissatisfaction out loud to another member of staff. We fed this practice back to the registered manager who said they would address this.

We saw staff knocking on doors and asking permission before entering rooms. One person said, “Generally, staff respect my privacy, they are caring and have learnt how to treat me but I do not like having so many different carers of

the opposite sex assisting me with my shower”. We fed this back to the registered manager. They confirmed they were in the process of reviewing this persons care plan with this in mind.

Visitors said, “Generally, staff are kind”, “Staff treat my relative well, they have lots of difficulties so I do things that I know they wouldn’t do, such as seeing to their hearing aid and making sure they wear their dentures at meal times”.

People looked well presented wore clean clothing that was appropriate for their gender and age. A hairdresser visited regularly but one visitor told us they had in the past needed to wash their relative’s hair themselves because it was dirty and greasy.

One person told us, “I am reviewing my care plan now and will make changes as required”. We spoke with one relative who confirmed they had been made fully aware when their relatives care needs had changed. Care plans contained information about what was important to people. Information included people’s wishes, likes and dislikes. We spoke with one member of staff who was able to give accurate information that related to one person’s personal preferences. We viewed four care plans and saw a ‘This is me’ document. This document provided personal information relating to the person’s life history including their previous occupations and family details. Information such as this is important when supporting people who might have dementia or memory loss. We saw care plans were reviewed monthly.

Is the service responsive?

Our findings

We reviewed people's care plans in relation to the care they received. We found most care plans reflected the care required and was based on the person as an individual. We found one care plan however did not reflect the change to the person and their ability to bathe. The care plan still made reference to the person being bathed once a week when in fact this had been stopped pending a review after an incident. We spoke with the registered manager who confirmed the person was under review at the time of the inspection and was not being bathed. They confirmed they would update the persons care plan and risk assessment in relation to the change in their care routine.

We saw where two people had recently had a deterioration to their skin there was clear accurate information relating to the care and support within their care plans. We found current risk assessments relating to their pressure sores and a body map identifying the area of concern. Care plans also identified the equipment and the level of support required from staff throughout the day and night. We spoke to a health care professional who was supporting one person with their skin. They confirmed they had good communication with Cambrian Lodge and that the service was good at phoning them when they needed to visit.

People felt they had choice about accessing the areas of the home. They told us "I am free to come and do as I please" and "there are no restrictions, I can do as I want and go anywhere I like but I prefer to sit here with my friends and chat or watch television". One person confirmed how they liked to stay in their room. They told us "I prefer to stay in my room, I enjoy my own company". We saw people chose to access different areas of the home throughout the day. Most people chose to sit in the room adjoining the dining room where most activities took place. Others preferred to remain in their rooms including one person who enjoyed watching birds from their window.

The home had a weekly activity programme. These activities were discussed at the residents and relatives meetings held by the home. Activities included nail care, music and movement, structured therapy and activities. In addition to this there was also music sessions and workshop sessions. Visits were also undertaken from the Methodist and Church of England ministers who regularly held a service and Holy Communion. Some people attended the local church with friends or relatives.

One member of staff confirmed how they always ensured people had choice and control. They told us "I will liaise with the [person] and give them two choices of the different meals available, I will verbally give them the choice and if needed show them".

People told us the home enabled them to access the community and maintain relationships with family and friends. On the day of the inspection one person had an outside support worker visit. The support worker confirmed how they might take the person out or spend quality time with them. They said they were there solely to support the person with what they wanted to do that day. We saw throughout the day people received visits from friends and family. They were able to sit in the communal areas or in their bedrooms to entertain their guests.

People told us they were aware of how to make a complaint and were confident they could express any concerns. One person said, "I would speak to the manager if I need to complain or if I had any concerns. Another person told us, "They are good to me but if I wasn't happy I would complain to the manager who is very nice" and "If I was unhappy about something I would speak to the manager or staff. I'm sure we could put it right between us all". One relative told us: "If I had any concerns or needed to complain I would speak to the manager". We looked at the complaints file. We saw where complaints had been raised the complaints had been responded and resolved appropriately.

Is the service well-led?

Our findings

At our last inspection in July 2014 we found the home did not have robust systems in place to identify areas of concern in relation to infection control and the maintenance of the building. At this inspection we reviewed the homes auditing systems and found there were still areas where the service was failing to undertake robust audits. Areas included infection control and the maintenance of the building. The identified areas of concern we found on our inspection have since been rectified.

We found the recent infection control audit had failed to identify certain shortfalls. These areas included all bathrooms having foot operated pedal bins for waste and a service having a current risk assessment relating to the laundering of infected clothes. We saw throughout our inspection the home had undertaken a range of building work since our last inspection. We asked to see the audit relating to the health and safety and maintenance of the building. This was not in place. We found the home had not been undertaking portable appliance testing. Some rooms had not been tested since August 2013. We also found gas certificates were out of date. The electrical insulation report completed in October 2014 confirmed an unsatisfactory report. Immediate remedial action was undertaken to ensure the electrics were safe. Other work required had yet to be planned and completed. We fed back our concerns to the registered manager who has since taken immediate action to ensure that these areas of concern have been addressed. We have also received written confirmation from the provider that these actions have been completed.

Prior to our inspection we had asked the provider to complete a Provider Information Return (PIR) containing information about the operation of the home. This had not been returned before the date the information needed to be submitted. The registered manager looked in their emails but was unable to locate a copy of the sent email.

The home had a registered manager and a deputy manager who were responsible for the day to day operation of the home. People were complimentary about both the manager and deputy and said they had a good relationship with them as did relatives, who thought the manager tried hard to make sure things run well.

The staff we spoke with told us they were well supported by the manager. Staff told us that there was an open door policy and that they could talk to the registered manager and deputy if they had any concerns. One member of staff said “I can always get answers and they are always available as well as easy to approach”. They also felt that the staff worked well as a team. They told us “I feel like we are a team here, I will support anyone who needs it, I have worked with one member of staff supporting them with their soft skills”.

There was training for staff in relation to Parkinson’s training, Dignity, End of life and continence training. We saw staff had also attended training in level 2 Dementia care. The manager and deputy had also attended a Dementia Care Matters conference. From this training they had plans to introduce positive changes to the building and service. This included how the home was colour coded and seen visually by people who lived there.

In August 2014 the home had sent out their Quality assurance surveys. This was sent to all people within the home. Only nine surveys were returned. Results from the survey identified people would like more information regarding Mental Capacity and Deprivation of Liberty Safeguards. We saw that this information was now displayed in the foyer and that a copy of the home’s complaints procedure was also available. There was a box the home used for compliments and complaints within the main foyer. Other actions had been discussed at the resident and relative meeting in October 2014. We saw discussions regarding menu choice, privacy and dignity, and if people were happy with the care, comments confirmed people were happy. We were told by the registered manager the providers quality manager would be looking to implement developing a group quality scheme and external audits for the home.

We saw that staff meetings were in place. The last meeting was held in October 2014. Areas discussed included Infection control and issues with the laundry and the redecoration. Minutes confirmed new sheets and bedding had been ordered and that team leaders were to record any falls.

We reviewed the incidents and accidents within the home. We saw that these were logged and reported with an overall monthly analysis and actions taken. Actions included providing referrals for specialist equipment and assessments to appropriate professionals. We reviewed

Is the service well-led?

one recent accident that we had been informed about. We found that a referral had been made to this person's specialist team and that the service had taken immediate action after the incident. We spoke with two visiting health care professionals. Both felt that communication in the home was good and that they felt appropriate contact and advice was sought when required. This meant that the service was liaising and taking appropriate action as required.

The home had a system in place to undertake regular water testing for legionella and temperature checks. There were regular checks carried out to ensure that the window restrictors were in place and secure. Tests relating to emergency lighting and door releases were in place and the home had regular fire tests.