Care Quality Commission

Bupa Care Homes (CFChomes) Limited

Elstree Lawns Specialist Nursing Home

Inspection report

Barnet Lane
Elstree
Hertfordshire
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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?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This inspection took place on 23 and 24 March 2015 and was unannounced.

Elstree Lawns Specialist Nursing Home is registered to provide accommodation and nursing care for up to 54 people. On the day of the inspection there were 31people using the service and a registered manager was in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

The provider used safe recruitment practices, staff had inductions and were supported with shadowing whilst

Summary of findings

developing skills. Supervisions and appraisals had not been completed but were being scheduled by the manager. Staff were aware of their responsibility to protect people from harm or abuse.

There was a newly appointed manager. The manager explained that they had prioritised staffing levels and training but improvements had been made since there appointment

Staff received regular training and knew how to meet people's individual needs. Any important changes in people's needs were communicated to all staff when they started their shifts, and there were regular daily meeting to discuss changes to people's needs.

The staff were knowledgeable about the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). Staff also understood the importance of giving people as much choice and freedom as possible. The manager had made appropriate applications for DoLS in order to keep people safe. Staff gained consent from people whenever they could and where people lacked capacity we saw that arrangements were in place for staff to act in their best interests.

People had appropriate food and drink and staff had access to accurate and up to date information to help them meet people's dietary needs. However there was not enough staff to assist people who required support during meal times.

There were planned weekly activities and entertainment was arranged by the activities co-ordinator. However during our inspection we did not see many people being involved with activities.

Staff were kind and people appreciated the positive relationships they had with staff. This was also true for relatives. People's privacy and dignity were respected and all confidential information about them was held securely. People using the service were complimentary about the staff providing the service. However we saw interaction from staff that was not supportive or caring.

Care plans were personalised and included information about people's life history and interests. People's individual needs were assessed and were specific to people as individuals. Staff were knowledgeable about how to manage people's individual needs.

The service was well led by a manager who promoted a fair an open culture. They encouraged staff to take responsibility. The manager had a support structure in place from area managers. There was a quality management system in place which included a system of audits to identify where improvements could be made and to identify trends.

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?

Requires improvement

The service was not always safe.

People felt safe and were cared for by staff who knew how to recognise and report concerns of abuse.

Staffing levels were not always sufficient to ensure that people's needs were met.

Recruitment procedures were robust and safe and medicines were managed safely.

Is the service effective?

Good

The service was effective.

People were not supported by enough staff at meal times, to meet their needs.

People had access to health care professionals where necessary such as GPs and opticians.

Staff received effective support and training and fully understood the MCA 2005 and DoLS.

Is the service caring?

Requires improvement

The service was not always caring.

Most staff were kind and patient,

Not all care delivered was supportive or caring.

People were listened to and their wishes were respected.

Is the service responsive?

Requires improvement

The service was not always responsive.

People were involved with planning their care. Individual concerns were addressed and changes were made to suit peoples preferences

The service had a complaints policy. People were aware of the policy and were confident to use it.

People were not supported to access the community and activities did not meet people's needs.

Is the service well-led?

Requires improvement

The service was well led.

There were systems in place for obtaining people's feedback and views.

Summary of findings

The service used self-assessments and audits to guide their improvement plans.

Both the manager and deputy manager were highly visible and approachable and led by example.

There were systems in place for the provider to monitor and audit the quality of the service provided.

Elstree Lawns Specialist Nursing 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 inspection was unannounced and took place on 23 and 24 March 2015. The inspection team consisted of one inspector and one expert by experience. An expert by experience is a person who has personal experience of caring for someone who uses this type of care service.

We also had a specialist advisor, who was a qualified nurse to advise us about the nursing care provided. Before we visited, we reviewed the information we held about the home, including statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us.

During our visit we spoke to nine staff, six people who used the service, six relatives and we spoke with an environmental health officer. We looked at four care records and three staff records. We looked at the quality of the nursing home environment and observed how staff cared for people. We looked at a range of policies, procedures and other documents relating to the running of the nursing home.

We also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who cannot fully express their views by talking with us. We observed people over lunch and found on the first floor there were not enough staff to meet people's needs. Not all staff treated people with dignity and respect. People were not supported to eat where required.

Requires improvement

Is the service safe?

Our findings

People who used the service told us they felt safe. One person said, "Yes, here I feel safe, I fell over and they helped me quickly". A relative told us, "I feel [Relative] has been absolutely safe here". Although people told us that they felt safe feedback from staff and from our own observations was that there were not enough staff available to consistently meet people's needs.

Staff told us there were not sufficient numbers to deliver care safely. One staff member said " I feel a lot of people are high needs and in the morning a lot of people require personal care and beds changing and there are not enough staff". Another staff member said, "It would be nice to have another pair of hands". We saw that breakfast was still being served at 11:00 am and were told by one staff member it was because of delays getting people ready in the morning. One relative said, "Staff are very patient with people but I am not absolutely sure there are enough staff."

While observing lunch we saw that on the ground floor where there were less people who required support to eat, lunch time was managed well. However, on the first floor staff explained that nine of the people required support to eat. On both days of our visit we saw people sitting at the table waiting for staff to be available to assist them to eat. People who were being supported by staff had their meals interrupted as staff had to attend to other tasks. We found that there were not enough staff to meet people's needs and we discussed this with the manager and the area manager. They both felt that there should be enough cover and would look at how the staff were organised.

We saw that the provider had a recruitment programme. The manager told us that they now had the correct numbers of nursing staff but still needed to employ more care staff however there were applicants still being processed. The manager had a system in place that assessed people's individual needs, this helped determine the staffing levels required. There were systems to cover staff shortages with the use of agency staff. The manager told us that staffing levels were a priority and that this had improved significantly. However we found that there were still not enough staff to support people with their meals and to meet people's needs.

We found that the registered person had not protected people against the risk of insufficient numbers of staff on duty. This was in breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with were able to describe what constituted abuse, "One person told us, "I feel safe here." Staff were confident about how to report any concerns they had. They were able to describe signs of abuse and indicators of people's behaviour that would raise concerns. All staff had received training in safeguarding adults. One staff member said, "I would report any concerns to the nurse or manager. Another staff member said, "I would report this to the manager and fill out an incident report and body map. A relative told us, "I feel [Relative] has been absolutely safe here."

Risks to people's health and wellbeing had been identified and steps taken to reduce them. However people were still supported to make life style choices. For example, we saw that where one person wished to smoke they were given the appropriate health advice but their choice to smoke was respected. Staff told us that, where particular risks were identified, measures were put in place to ensure the risk was safely managed. For example we saw that one person had been referred to the Speech and Language Therapy Team (SALT). This was due to the person having lost weight and coughing when swallowing fluids. It was noted that the staff had recently commenced the person on thickeners and a pureed diet. Risks to this person had been identified and managed appropriately, this included involving other professionals to support people's needs.

We saw that people received their medicines as prescribed. One person said, "I get tablets ok." Medicines were stored managed and administered safely. There were systems in place to manage medication. We saw that people were supported, where necessary and appropriate, to take their medicines at a pace that best suited them and their individual needs. People were supported to take their medicines by staff that had been trained to administer medicines safely. We saw that the medicines round was conducted by appropriately trained nursing staff and that medicines administered were recorded appropriately and accurately to reflect what had been given. Where covert medicines had been given the correct assessments and procedures were in place.

Good

Is the service effective?

Our findings

One Relative told us, “The staff seem well trained to carry out their duties here”.

We found that staff had received relevant training to help them do their jobs effectively. For example they had received training to help staff understand the needs of people living with dementia and people whose behaviour may challenge others. New staff were supported and mentored in the work place by experienced colleagues. There was an induction plan followed by shadowing other staff to ensure their proficiency. One staff member confirmed that they had worked at the home for six weeks and had completed their induction and shadowing with experienced staff. They said, “That they felt supported and were enjoying their new job.”

We found that staff were not supported by regular supervisions and appraisals to help with their professional development. Staff had not received individual time to discuss their development needs. We saw that the manager had started to put this in place and there had been two supervisions completed. The manager said that since starting six months ago that their priority had been staffing levels and training. They also told us that supervisions and appraisals were very important and confirmed that this was being addressed.

Staff we spoke with understood their responsibilities under the Mental Capacity Act 2005 (MCA). They explained the importance of giving people as much choice and freedom as possible. One staff member said, “It is important for people to have choice.” We saw in people’s care plans that capacity assessments and best interests had been followed. People’s families were involved where people lacked capacity and the manager was aware of the role of the independent mental capacity advocate’s service if required. We observed staff gaining consent with the support they were giving in assisting people. The manager had appropriately made applications for Deprivation of Liberty Safeguards (DoLS). We found where bedrails had been used that assessments had been completed and DOLs applications were in place. Staff also understood the importance of giving people as much choice and freedom as possible.

One person told us, “I do like the food” and “I get plenty to drink”. People were given nutritionally balanced meals, there were options to choose from daily and if required there was an alternative for people. All food allergens were listed, for example, wheat and soya. We saw that there was food that catered for people’s cultural needs. We saw people had been supported by the Speech and Language Therapy teams. For example where people had found swallowing difficult they had been placed on soft food diets and we saw staff using thick and easy. One relative said, “My relative is having pureed food and thickened drinks”. The chef held a list of all the people who used the service; this list contained all their individual dietary needs. We saw that food was served throughout the day and people were supported by staff to drink. People had been supported to have enough to eat and drink. However we found at meal times on the first floor that due to staffing numbers that people’s needs were not met. We spoke with an environmental health officer who told us that hygiene standards at the home were excellent.

We saw one resident who required covert medicines. We found that medicines were listed with rationale, benefits and alternatives with reference to mental capacity assessments. The family had been involved and there was evidence of the pharmacist’s involvement in the decision making. This meant that the person’s best interest had been looked at to provide care that met the person’s needs.

We saw that there was good care planning and risk assessments in place to meet people’s needs. This included pain management, and a safety personal evacuation plan. There were risk assessments for bedrails and bumpers and moving and handling. We saw that people’s needs were assessed and reviewed regularly.

One resident had been admitted for palliative care and professional contacts included the Macmillan nurse and the tissue viability nurse. Weight loss was noted and the person had a history of choking. Skin integrity was assessed via Waterlow scoring (The Waterlow score gives an estimated risk for the development of a pressure sore in a given patient). The resident was nursed on a pressure relieving mattress and cushion. There were assessments for mobility, sleeping, breathing, temperature and pain. There were end-of-life decisions, mental capacity assessments and a DOLS in place. Best interest decisions for example for ‘staff to act as advocate for them'. Future decisions including preferred place of care and the requirement for staff to liaise with the Macmillan nurse for advice .There was

Good

Is the service effective?

good care planning and evaluation regarding pain management.. This showed that people received care based on best practice and that they were supported and had access to other healthcare professionals.

People were supported to access additional healthcare services where appropriate and in accordance with their needs. One person said, “I can see the doctor when I want” and “I had an eye test”. We saw, and records confirmed that people’s health needs were monitored and discussed with them. We observed at meetings held every day with all senior staff and the manager. That people’s health needs and any changes were discussed. We saw that when required, referrals were made to other professionals such as the GP and dieticians. One relative told us, “They organise visits from the doctor, the hairdresser, the dentist and the podiatrist”.

Requires improvement

Is the service caring?

Our findings

One person told us, “They [Staff] do help me a lot” and “They are very nice people” and “Yes, I’m sure they look after me well, they make me laugh sometimes”. A relative said, “Staff are lovely, warm and caring”.

However we saw a person being supported by staff to eat. The person had their eyes closed the whole time while eating. The staff member offered up the spoon of food to the person’s mouth without any communication. This meant the person was only aware of the food once the food touched their mouth. The staff member left the person they were supporting twice during the meal to perform other tasks, this was done without communicating this to the person. After they returned the second time they removed the plate of food from the table and returned with some dessert. This was done without asking the person if they had finished. This did not promote dignity and respect and did not promote the persons independence.

We also saw on two occasions where people’s feet were placed onto the footplates of their wheelchair. This had been done without explaining to the people what staff were about to do. We also saw where one person had fallen asleep in their chair at the dining table, the staff member held the back of the chair and turned the chair around without any communication to the person who was asleep at the time. Again this did not ensure peoples dignity and respect were maintained or promote their independence or wellbeing.

We found that [the registered person had not protected people against the risk of a lack of dignity and respect. This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

A relative said, “The staff are very pleasant, [Relative] teases them and they respond to him”. We saw positive interactions between staff and people who used the service. We saw people supported from their wheel chairs into chairs in the lounge, this was done with care and plenty of communication to reassure the person who they were supporting. We saw where one person was feeling frustrated and was raising their voice the staff spoke with them in a calm manner reassuring and supporting the person who quickly stopped shouting and was calmer in their response. People were complimentary about the staff that looked after them. One person said,” The staff are very attentive”. We saw that staff were patient and gave encouragement when supporting people. People commented on the friendliness and kindness of the staff.

Staff told us about the importance of privacy and dignity. One person said, “I always knock on people’s doors and introduce myself. I make sure the doors are closed and curtains are drawn when assisting people with personal care. I make sure it’s ok to give personal care because not everyone wants personal care from a male carer.” We spoke to staff and they were able to discuss the importance of respecting diversity and people’s human rights. One person said. “Staff are ok, they look after you. Happy with the way they respect my dignity.”

We saw that not all people had capacity to be involved with planning their care but where required peoples best interests were supported. We saw in peoples care plans that capacity assessments and best interest decisions were well documented. People and their families were involved with their care. One relative said, “Staff are really good and communicate really well about their [Relative’s] needs. I have been involved with my [Relatives] care planning and they have responded really well since being here.” People who used the service and their relatives were given information and guidance about all aspects of the service. This included information on how to raise any concerns. A relative said, “They do let me know what’s going on”. People are invited to attend relative meetings and the manager has an open door policy to enable people to talk to them about any issues they may have. One relative said, “I can approach the manager at any time and they are amazing because they are in touch with all the residents.”

Requires improvement

Is the service responsive?

Our findings

One relative told us, “There is an activities room and [Relative] chooses to do what they like”. The activities co-ordinator told us that they talked with people and they looked at people’s interests and hobbies to help develop activities people may like to participate in. We saw the activity planner that listed things to do such as: Armchair ball games, film afternoon for both floors and arts and crafts. One person said, “I enjoy playing the games”. The activity co-ordinator told us that they had a library that also supports people who cannot see, for example it provides them with audio books and people have made requests for books that they are interested in. One person who was interested in horses, staff told us that they had requested material on horses to support their interest. The activities co-ordinator explained that the activities were put together from talking with people and their families and looking at what people are interested in. This information was recorded in people’s care plans. One relative said,” My relative gets little stimulation and could benefit from something, like ball games or musical entertainment”. One person said,” “I like singing and listening to music”.

However we found that for the two days we were there, although a programme of events had been planned, little activity was observed to be taking place. People spent most of their time sitting around in the lounge with music in the back ground. We saw that lots of people were sleeping in chairs. There were no plans for people to go out locally. There was always a staff member in the lounge to support people. We spoke with the manager about this and they agreed that the activities needed to be reassessed and would be looking to improve these.

We found that people using the service that had been able to had contributed to their assessments and care planning. We saw that people’s preferences, life style choices and aspirations had been sought to promote individual care.

We also saw that relatives had contributed to the care planning process. We spoke to one relative who told us, “The care is personalised”. There were regular meetings held for family and friends to be involved in the home and an opportunity to discuss any ideas or concerns that they might have. One relative told us, “They do hold relatives’ meetings”. We saw from the minutes of meeting that topics talked about ranged from: catering, flu jabs and activities. The manager told us that relatives had asked for support around better understanding dementia. The manger arranged for a coffee morning to be attended by a person from the Alzheimer’s Society and relatives. The first one was attended by five relatives and will be held every three months. The coffee morning offers support to relatives and gives them a chance to get together and talk about their concerns and have questions answered.

The manager told us about a meeting held every day at the home. The meeting was attended by all senior staff and the manager to discuss any concerns and changes in the home. We attended the meeting and listened to the staff discuss issues or changes. One nurse confirmed that there had been no referrals on the day of our inspection and that the intensive outreach team were visiting to reassess a person under their care. This daily meeting showed that risks and peoples care needs were assessed on a daily basis.

Staff told us they knew they could speak to the registered manager if they had any concerns. Relatives also confirmed that they knew how to raise concerns. They told us that staff and the manager were approachable and had confidence their complaints would be dealt with. One relative said, “I did complain and they sorted it out very quickly”. We looked at the complaints log and we found that the complaints received had been fully investigated and responded to there were action plans in place to resolve any issues or concerns raised. People’s complaints were responded to in a timely manner.

Requires improvement

Is the service well-led?

Our findings

People we spoke to thought the Home was managed well and the staff seemed to work as a team. Staff told us that they felt supported and enjoyed working there.

The manager had been in post for six months and with support from area managers had begun to make improvements. For example, the provider had placed a self-imposed embargo that stopped the intake of any new residents. This was done because of staffing levels and training needed to improve. The manager had a good recruitment system in place and had now a full complement of nursing staff and had nearly completed their recruitment for care staff with interviews being held. There was a training matrix in place that showed staff were completing training. The manger had a service improvement plan and had prioritised staffing levels and training. The local authority on their last visit in February 2015 had agreed that the improvements made thus far were enough to remove the embargo that was in place.

The manager told us they encouraged people and staff to make decisions about how the home operated. This was done through regular meetings to discuss issues and ideas and allowing people to develop their ideas. An example given by the manager, where improvements had been made. Staff had suggested handovers would be better if the care staff could attend. Instead of having this information passed on to them by the senior staff. The manager introduced this on a trial basis and the trial was very successful and all handovers are now completed with care staff present.

We saw that the manager was very visible and demonstrated a good knowledge about people who used the service. The manger carried out regular tours of the whole service. They spoke with people and staff about their views and experiences. We saw that the manager also completed environmental checks at the same time to ensure standards were maintained and people kept safe. One relative said," The management will act on any issue and deal with it straightaway" and "I am very happy with things here". The manager told us that they have an open door policy and made themselves available to people who used the service, relatives and staff. A relative said, "I see the manager often and she would see me if I wanted" another said, "The manager and deputy are very approachable".

The manager was supported by an area manager and they have regular monthly meetings. The manager told us that quality assurance managers who worked for the provider carried out monthly spot checks of the service to ensure that standards are maintained and to drive improvement. However although the manager confirmed that activities had been identified as needing improving the staffing issues at lunchtime had not been identified, this meant the monitoring did not highlight all areas that required improvement. All managers met regularly for training and for passing on good ideas and practices that they have. The manager told us that they can just pick up the phone to speak to another manager for support when needed. This meant there was a system in place to support the manager and promote improvement. The home had a service improvement plan in place that looked at issues found and how to resolve the issues and a completion date for actions to be taken.

The manager had made steps to improve the service with recruitment and training, however there were areas that required improving. For example, only two staff had completed their supervisions at the time of our inspection.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. The manager had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

The manager used a quality metrics report that included information from all pressure ulcers and nutrition including weight loss . A medicines audit had been carried out by Boots in February 2015. In addition there was audit activity on GP reviews, bedrails, infections, care plan reviews and actions, training, accidents and incidents, complaints, concerns and compliments and resident involvement. All the information was used to identify trends that would help the manager to recognise potential areas for improvement.

We were able to see that positive actions were taken to learn from incidents. For example, when an incident had taken place, the manager reviewed the circumstances and took steps to reduce the risks of these happening again and made sure that people were safe. We saw that the manager had a system that used all information from audits, accidents and incidents, customer feedback, concerns and complaints. This information was used to monitor trends and enabled areas of concern to be highlighted. For example, in January we saw a rise of chest

Requires improvement

Is the service well-led?

infections and again in February but this was reducing. Although this was improving by its self it showed that there were systems to see trends to alert the manager to potential problems.

The service used a"barrier board" for staff to raise any issues or concerns they may have that may be a 'barrier' to them performing their roles effectively. It then becomes the manager's responsibility to resolve the issue. For example, we saw an issues raised previously by one member of staff about the number of wheelchairs and their condition. The manager had this looked at and found that they did need more wheelchairs and eight more were ordered. Another example was that nurses said that they required more equipment again this was audited and equipment was ordered. A weekly check of stocks are now done to maintain good stock levels on nursing equipment. If the manager was unable to resolve any issues raised the problem was dealt with by the next level of management until resolved. This showed people were listened to and concerns raised were responded to.

The manager promoted an open culture and encouraged people to speak out. This approach was promoted at meetings and staff we spoke with told us that the management team were very approachable. One relative said, "the management seemed approachable and would sort out any issues." The manager said, "one of the things I am proud of since starting here is the staff it is important that staff and people feel supported and are confident to express any concerns. Staff we spoke with were aware of the whistle blowing policies and contact numbers for people to call should they have concerns were available.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** **The provider did not ensure peoples dignity and respect or promote their independence.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **The provider did not ensure sufficient staff to meet people's needs.**