Knights Care (2) Limited

Ladysmith Care Home

Inspection report

Ladysmith Road
Grimsby
South Humberside
DN32 9ND

Tel: 01472254710
Website: www.knightscare.com

Date of inspection visit:
17 September 2018

Date of publication:
22 October 2018

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 17 September 2018 and was unannounced. Since the last inspection on 6 January 2017, the provider has slightly changed the name of the organisation to bring their two services under one organisation, but it in effect remained the same. At the last inspection, we had concerns about the management of medicines, documentation relating capacity legislation, care plan records and quality monitoring; the service was rated as Requires Improvement. At this inspection, we saw significant improvements in all areas and the service has been rated Good.

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

Ladysmith is a large service set over two floors and can support a maximum of 90 people with a range of health care needs. Some people who used the service were living with dementia and there was a separate part of the service upstairs equipped to meet their needs. All the bedrooms are for single use and all have en-suite facilities. There are communal rooms, bathrooms and toilets on each floor suitable for people's diverse needs. At the time of the inspection, there were 31 people upstairs in Orchid and Lilac units and 42 people downstairs in Heather and Lavender units.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was on annual leave so the deputy manager and provider supported the inspection.

The overall governance of the service had improved. Advice and support had been externally sourced, which had provided structure to quality monitoring and facilitated staff development. Audits and checks were completed. Meetings with people who used the service, their relatives and staff took place, and surveys were completed. Shortfalls were identified and a service development plan produced to drive improvements.

People had assessments of their needs and the care plans produced to meet them had improved. They were much more individualised; they included guidance for staff in how to meet people's needs in ways they preferred.

People received their medicines as prescribed; there was an improvement in recording when items such as creams and lotions were applied. Medicines were stored safely and re-ordered in a timely way so people did not run out of them.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. The

documentation for capacity assessments and to support best interest decisions had improved.

People's health and nutritional needs were met. Staff supported people to access health professionals when required and they could remain in the service for end of life care if this was their choice. People liked the meals provided to them, although some people said they could be hotter when served and they would like an additional choice at the main meal. The registered manager told us they would address this with catering staff.

People who used the service and their relatives had positive comments about the staff team and their approach when supporting people. People's privacy and dignity was respected.

Staff had completed safeguarding training and knew how to protect people from the risk of abuse. They completed risk assessments and supported people to carry out daily tasks with the minimum of risk involved, without removing their choice and decision-making.

Staff were recruited safely and there were sufficient staff deployed to meet people's needs.

Staff had access to training, supervision, support and development. They described the management team as supportive and available when they needed to talk to them.

There was a complaints procedure displayed in the service and people felt able to raise concerns and complaints.

The environment was clean and tidy and staff had access to personal protective equipment to help prevent the spread of infection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff had received training in how to safeguard people from abuse and harm, and knew how to raise concerns. People had assessments to identify areas of risk and staff supported people in ways that helped minimise risk.

People received their medicines as prescribed. There were systems in place to ensure correct ordering, storing, administration and returning of unused medicines.

Staff were recruited safely and deployed in sufficient numbers to meet people's needs.

The service was safe, clean and tidy.

Is the service effective?

Good

The service was effective.

People's health and nutritional needs were met. Staff contacted health professionals in a timely way when required.

Staff supported people to make their own decisions. When they lacked capacity to do this, the provider and registered manager included relevant people in decisions made in their best interest.

Staff had access to training, supervision and support, which enabled them to have the skills, knowledge and confidence required to effectively support people's needs.

The environment had been adapted, in line with evidenced-based guidelines, to meet people's needs.

Is the service caring?

Good

The service was caring.

There were very positive comments from people who used the service and their relatives about staff approach.

Staff supported people to maintain their privacy and dignity in a kind and caring way. They assisted people to be as independent as possible and made sure they had information to make decisions.

People's personal information was held securely. Staff knew how to maintain confidentiality.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and care plans produced to guide staff in how to support them in the way they preferred.

People could remain at the service for end of life care, if this was their choice, with support from community nursing teams.

There were activities arranged for people to participate it and outings to local venues.

The provider had a complaints procedure and people who used the service felt able to raise concerns.

Is the service well-led?

Good

The service was well-led.

There was a structured governance system in place which consisted of audits, checks, meetings and surveys. The provider was closely involved in governance and had oversight of the service.

The culture of the service was open and inclusive. There had been a recent drive to develop the staff team to ensure they felt included and had ownership of what they did well and what they needed to improve.

Staff told us they felt supported by the management team and could raise issues with them if required.

Ladysmith Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 17 September 2018 and was unannounced. The inspection 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. The expert-by-experience had expertise in caring for an older relative who lived with dementia.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also checked our systems for any notifications that had been sent in as these would tell us how the provider managed incidents and accidents that affected the welfare of people who used the service.

Prior to the inspection, we contacted various agencies for information. These included local authority safeguarding and contracts and commissioning teams.
We spent time in communal areas and observed how staff interacted with people who used the service throughout the day and at lunchtime. 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 nine people who used the service and three people who were visiting their relatives. We spoke with the provider, the deputy manager and four members of the care staff team. We also spoke with an activity coordinator, a cook and a visiting health professional.

We looked at four care files which belonged to people who used the service. We also looked at other important documentation relating to them such as medication administration records (MARs) for 31 people and monitoring charts for food, fluid intake, weights, wound care and pressure relief. We looked at how the service used the Mental Capacity Act 2005.

We looked at a selection of documentation relating to the management and running of the service. These included four staff recruitment files, training records, the staff rota, minutes of meetings with staff and people who used the service, quality assurance audits, complaints management and maintenance of equipment records. We completed a tour of the environment.

Good

Is the service safe?

Our findings

People told us they felt safe in the service and there was sufficient staff on duty to meet their needs. Comments included, "I don't have a single worry here", "They [staff] always pop in to see if I'm okay and sometimes they take me to the lounge", "They pop in at night to check on me" and "They [staff] are here for everything and always make me feel it's no problem."

We observed the atmosphere in the service was calm and relaxed.

Staff knew how to safeguard people from the risk of abuse and harm. There was a safeguarding procedure to provide staff with information and they had received training. In discussions, staff were knowledgeable about the different types of abuse and the action to take should they witness abuse. The provider's whistle blowing policy was on display on the notice boards and staff were encouraged to raise concerns so these could be addressed.

Staff also knew how to manage risk. Each person had a range of assessments to determine risk in specific areas. These covered areas such as nutrition, falls, behaviours that could be challenging due to anxiety or distress, moving and handling and fragile skin. Staff were aware of the risks and knew how to support people to minimise them.

People received their medicines as prescribed. All the people spoken with said their medicines were brought to them on time and they never had to ask for them. A relative said there had once been an issue with the timing of pain relief, but as soon as this was discussed with staff it was addressed straight away.

Staff used a pictorial pain level scale to assist them when determining if pain relief, prescribed 'when required' (PRN), should be given to people. There were protocols in place for most PRN medicines or those with a variable dose to ensure staff had clear directions; the deputy manager told us she would audit the medication file and ensure they were available for all these medicines. Staff used specific codes to identify the reasons when medicines were omitted, for example, if the person declined them or they were in hospital. There were systems in place for ordering, storing and returning medicines when no longer in use. Staff who administered medicines had received training and team leaders completed observations of their practice. We saw there had been improvements in the way prescribed creams were recorded when applied to people.

The provider recruited staff safely and ensured full checks were in place before they employed them. Staff completed application forms to enable gaps in work history to be assessed, they provided two references and attended for an interview. The provider completed a check with the disclosure and barring service (DBS) to ensure potential candidates were suitable to work with people who used the service.

Rotas showed us there were sufficient staff deployed in the service. There was a range of staff at different levels and skill mix. When people were asked about call bell response times they said, "It's alright, they know if I ring my bell I need the toilet quickly and they respond quickly. Occasionally, if they busy I have to wait in

the toilet but they still care when they are so busy" and "It's very quick [response time] but if they have a delay, someone pops in to see if I can wait; they tell me how long they will be and always come back. If I can't wait they get someone straight away."

Staff told us they felt there was sufficient staff. Comments included, "We're fully staffed now. We get the occasional sickness but people come in if we ring them", "Yes, we have enough staff and we have never had to work short" and "We [team leaders] are supernumerary and an extra body so we can step in; the floor is not short." A health professional told us they felt there was sufficient staff and staid, "They are pretty good here."

The service was safe, clean and tidy. Staff had access to personal protective equipment, which helped to prevent the spread of infection. Equipment used in the service was maintained and checks made to ensure it remained safe to use. One visitor told us there was intermittent issues with hot water in their relative's bedroom. The deputy manager told us this was being addressed.

Good

Is the service effective?

Our findings

People told us staff supported them to meet their needs. Comments included, "I just ring my bell and they help me with whatever I want. We always have a good laugh and they explain what they're doing."

A health professional told us staff were knowledgeable about people's health care needs and they contacted community nursing teams in a timely way if they had concerns.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take 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 authorisation procedure for this in care homes is called Deprivation of Liberty Safeguards (DoLS).

People who met the criteria for DoLS had their capacity assessed and 39 applications had been made to the local authority supervising body. Ten of these had been authorised and the remainder were awaiting assessment. Capacity assessments were held in people's care files and when decisions about care were required, these were discussed with relevant people. The outcomes of discussions were recorded on appropriate best-interest decision forms and signed as agreed by the participants. This meant important decisions were discussed and only made when they were in people's best interest and the least restrictive option.

Staff had a good understanding of consent and described how they obtained this before carrying out care tasks. Comments included, "MCA is about protecting people's rights. We use communication, show people their choices and help them make their own decisions. We get information from families about likes and dislikes", "We have MCA and DoLS and best interest decisions in place; I check on these" and "We can get an advocate to protect people's rights." Staff completed training on MCA and DoLS. People told us staff supported them to make their own choices and decisions, for example with times of rising and retiring to bed, where to sit and what activities to participate in. Comments included, "I go to the lounge when I am ready. Any special event or excuse for a party, we have one; we have Tai Chi later this morning. I do as I like."

Care files showed us people had access to a range of community healthcare professionals when required. This was confirmed in discussions with people who used the service. Comments included, "Oh, its excellent. I had a problem and a carer went with me to hospital and stayed well past her shift time" and "It's very good. When ill, they soon assess if we need the doctor and the care is fantastic." A relative told us, "Its instant; any problems and the nurse will be on the phone getting antibiotics if needed; they are very prompt."

People's nutritional needs were met. Nutritional risk was identified and referrals made to health care professionals when required. People at risk were monitored closely with food and fluid charts to record what they had eaten and drank. People were weighed in line with their risk status, either weekly or monthly.

There was fresh fruit, crisps and juices available in sitting rooms for people to help themselves and we observed staff offering drinks and snacks to people throughout the day. The chef told us they provided two 'grazing trays' of snack food for the people living with dementia on units upstairs. They received information about people's special diets and nutritional needs from senior staff.

Most people told us they liked the meals prepared for them although some said these could be served hotter. Comments included, "Its very good; we get plenty to eat and drink. There is no choice [only one choice at the main lunchtime meal] but they will get me something if I really don't like what they bring", "I love the soup and we always have soup at dinner" and "I have no complaints with the food and I'm a faddy eater." We spoke with the provider and deputy manager about having at least two main hot choices on the menu for the lunchtime meal. They said this would be discussed with the chef and addressed. They told us they would also ensure plates were warmed properly before food was served to people. The deputy manager told us they would monitor this and speak with people who used the service to check that improvements were made.

Staff had access to training, supervision and support. Training records identified courses considered essential by the provider and additional ones such as end of life care, dignity, equality and diversity and person-centred care. Staff confirmed they had sufficient training and this enabled them to feel confident when supporting people. Staff said, "We get more than enough training and it gives us the skills we need; there are refresher courses" and "There is loads of training; I love it." New members of staff told us their induction had been thorough. They said, "I shadowed staff and was partnered to senior staff; they explained everything such as routines to suit people's needs. I settled in quickly."

The environment was suitable for people's needs. Improvements had been made to the environment, in line with best practice guidelines, to make it more dementia friendly. These included large colourful pictorial signs in the dementia care unit on bedroom doors, toilets and bathrooms, murals of shop fronts on corridor walls and reminiscence items. The lighting throughout the service was bright. There were pictures of old familiar items on the dining room walls that could initiate conversation. There were grab rails in corridors and equipment to help staff move and handle people safely. There was safe outdoor space to enable people access to fresh air.

Good

Is the service caring?

Our findings

There were positive comments about the staff approach and their support of people. Comments included, "The way the staff look after me, nothing's too much trouble; I couldn't look after myself. I don't have a single worry here", "The staff are all ever so nice", "Oh, it's excellent here; I don't regard them as carers, they're more like family" and "If I get visitors, they always offer them a drink and a biscuit. When my relative comes they offer her a meal and don't charge her; they are so welcoming."

A relative said, "It's the staff, they just treat everyone like they are their own relative; I can't fault them." A relative described how they had observed staff being very kind and patient with people who used the service. Relatives were offered refreshments from the tea trolley in the afternoon.

People told us staff treated them respectfully and maintained their privacy and independence. Comments included, "The staff treat me with dignity and love, and they help me to be independent. I really couldn't fault anything at all", "I have a shower or a bath twice a week; it's up to me whether I have one. They [staff] help with what I want them to", "They always let me do what I can and help when I need it" and "The carers always check if I'm ok with what they are doing and explain everything."

In discussions with staff, they described how they promoted people's privacy, dignity and independence. We observed staff spoke with people in a kind and patient way. A person who used the service was asked if staff could take their blood pressure and if this could be done in the privacy of their bedroom. The person was happy for this to take place. We observed positive interactions between staff and people who used the service, which prompted smiles and signs of wellbeing. One senior member of staff had been appointed a 'dignity champion' and their role was to remind staff of the importance of maintaining dignity and to identify areas of practice that could be improved.

The provider had a policy and procedure on equality and diversity. This had been the 'policy of the month' for August 2018. A poster was on display and gave staff a brief overview of the policy objectives, which referred to a 'zero tolerance' to perpetrators of discrimination and ensuring an open and inclusive environment. Staff had completed training in equality and diversity.

Staff were attentive to people and provided explanations to them before carrying out tasks. This was observed during lunch. Staff were helpful and encouraging when supporting people to the dining area and when assisting them to eat their meal. Staff asked people if they wanted to wear clothes protectors, if they wanted their food cut up and if they wanted second helpings. One member of staff was observed comforting a person by sitting and holding their hand. We observed one person was in distress and an ancillary member of staff went in to their bedroom to see if they could help. As soon as they realised a care worker was required, they told the person they would get someone to help; a care worker went to assist them very quickly.

People were provided with information throughout the service. Menus were on the dining tables. There was a photograph of each person's keyworker in their bedroom. There were notice boards with activities, a

newsletter, pictures of staff, the complaints and whistle blowing procedure, dates of 'surgeries' held by the registered manager, reminders about hydration and the values of the organisation. There were two notices on display, which reflected specific values. These were, "A hundred languages around the world, but a smile speaks them all" and "Our residents do not live in our workplace, we work in their home." During the inspection, we saw staff adhered to these values. There were pictorial signs to help people find their way around the service.

Senior staff were aware of advocacy service and supported people to access them when required. There was one person currently using an advocacy service for support with their decisions.

Staff maintained confidentiality and used offices to make phone calls to health professionals or to discuss issues in private. People's personal care records were held in lockable cabinets and staff personnel files were held securely. Review meetings to discuss people's care were held in their own bedrooms or an office. Computers were password protected to ensure only appropriate staff had access to them.

Good

Is the service responsive?

Our findings

People told us staff were responsive when meeting their needs and most remembered seeing their care plans. They also told us there were opportunities to join in planned activities. Comments included, "I'm not sure about my care plan but they regularly talk to me about what I want", "I saw my care plan at the beginning and [Name of staff] did a review", "My room looks and feels like home and I get lots of visitors", "Sometimes we have entertainers come in and sometimes a mini bus takes me out to a garden centre, which I enjoy", "We have regular quizzes which I love and in good weather we get the chance to go outside" and "I like the exercises on a Monday, but she [one activity coordinator] is on holiday today so I had my nails done instead."

A health professional told us staff were responsive and they had witnessed good interactions and a positive approach from staff when supporting people.

People had assessments and risk assessments carried out to determine the level of their needs. The assessments were used to help staff formulate care plans. There had been improvements in care plans and we found they contained good information to guide staff in how to meet people's needs in ways they preferred. For example, one person's care records described what would be a typical day for them with preferred routines. It referred to preferences depending on their mood and gave staff different options to explore with the person. There were social profiles which described what upset the person and how these could be avoided. Another person's care plan described the topics staff could use to distract them if they became upset.

In discussions with staff, it was clear they knew people's needs very well and could deliver care in a person-centred way. The care plans included personal histories and likes, dislikes and preferences. One example of how staff responded in a person-centred way was provided by a relative. They told us their relative had to lie in bed on a specific side so would wake up looking at the wall. The staff arranged for the person to move to another bedroom, which meant when they woke up they were facing their personal and familiar belongings. The person who used the service and their relative told us they were very pleased with this arrangement and the kindness of staff had made a difference to her.

Staff told us they had changed the way they evaluated care plans so they could respond to changes in a timelier way. They said that every day, one person's care plan on each unit was reviewed. The cook and housekeeper were involved, a stock check of the person's medicines was completed and the activity coordinator spoke to them. They said this format enabled them to review different aspects of people's care. One member of staff said, "The care records have really improved."

Bedrooms were decorated and furnished in an individual way and people had brought in their favourite possessions to make it homely.

The provider had a policy and procedure for end of life care. People could remain at Ladysmith Care Home for end of life care with support from community services. Some people had care plans which detailed their

end of life wishes.

People could participate in activities and spoke highly of the entertainment arranged for them. The service had three activity coordinators who worked various shifts throughout the week; one day a week, all three worked in the service. There are no activities on a weekend; staff told us the weekend was more of a family time with visitors. An activities plan was on display and included a range of activities. These were art and craft work, quizzes, baking, exercises such as Tai Chi, 'knit and natter', reminiscing, manicures and hand massages, dancing and skittles. There were also church services, trips to local facilities and visiting entertainers. The activity coordinator told us they completed one to one sessions with people in the dementia care units. There was a 'resident of the day', whereby staff learned more about the person; there was also a record made of activities people had participated in and whether they had enjoyed them.

The provider had a complaints policy and procedure which gave timescales for acknowledging complaints and investigating them. Complaints were recorded and this showed they were investigated and addressed. People said that if they had any concerns they would be able to raise them. Comments from people who used the service included, "I've never had to complain but I would speak to [Name of staff] or one of the others; there is not one staff I wouldn't be able to talk to." A relative told us they had raised an issue once and it was dealt with efficiently and straight away.

Good

Is the service well-led?

Our findings

People who used the service were positive about the staff team and the support they received from them. People told us they knew who the registered manager was and could raise issues with them when required. Comments included, "I know where to find [Name of registered manager]; I see them at odd times but I've never had to see her. I love it here" and "Oh, you mean [Name of registered manager]; she's very approachable." A relative said, "We know the manager; they are very approachable but so are [Names of team leaders]. The seniors are excellent and they are in charge at weekends."

There were improvements in the way the serviced was monitored. The provider had obtained advice and support from an external source, which had assisted them to structure governance of the service. The provider visited the service on a weekly basis and received monthly reports from the registered manager. This ensured they had oversight of the service and they knew how quality was monitored. The external support completed quarterly compliance visits and produced an action plan for any identified shortfalls. There was an annual audit plan completed by the registered manager and senior staff team. These audits consisted of areas such as medicines management, care documents, infection control, accidents, nutrition and weight loss, staff training, housekeeping, and equipment such as bedrails. Shortfalls from checks and audits were collated into a service development plan. The provider and external support monitored the service development plan to ensure actions were completed. The provider had meetings with the registered manager to review progress of the action plan. One member of staff involved in auditing said, "The audits and checks are a lot stronger now; we know where the issues are and we address them quickly."

We discussed improvements since the last inspection with the provider. They felt these included people's care plans, an increase in staffing numbers, new furniture and flooring, and staff team development. The provider gave us an update of their refurbishment plan, which had timescales for completion. These improvements were observed during the inspection and discussed with the staff team. There were positive comments from the staff team about changes since the last inspection. These included, "This is a great place to work; it's a lovely home from home", "It's now more positive at Ladysmith; lots of things have improved, for example care records. It's better than it was before", "Some staff have gone; the staff now give full respect to each other and we work well together" and "It's definitely better than it was at the last inspection; staff are more knowledgeable about their role."

Staff development had been an important part of the changes. There had been sessions with the staff team to identify what they did well and the areas they wanted to be better at. There was a team meeting feedback session, which discussed the results and plans for their next inspection. The values of the organisation were on display and these linked to a staff charter. These ensured staff were aware of how they were expected to work and in return, what staff could expect from the provider.

The staff team told us they had meetings and were well supported by the registered manager and the provider. Comments included, "The management team are very supportive", "The management team are around the building in the early mornings. They see the residents and the night staff, and they check equipment" and "I feel supported and I support others."

There were meetings for people who used the service and their relatives, and surveys to obtain their views. The results of the survey were on display it the form of 'What we do well' and 'What we could do better'. The registered manager held 'surgeries' on certain days for those relatives who were unable to visit during office hours.

The registered manager and staff team developed relationships with health and social care professionals involved in people's care. They made referrals to community teams when required. A health professional told us they had a good rapport with all staff and would go to the registered manager with any concerns.