Mrs Zeenat Nanji & Mr Salim Nanji

Beverley Lodge Nursing Home

Inspection report

122 Grove Road
Sutton
Surrey
SM1 2DD

Tel: 02086434128
Website: www.southcarehomes.com

Date of inspection visit:
01 February 2016

Date of publication:
29 February 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We undertook this unannounced inspection on 1 February 2016. At our previous inspection on 22 July 2014 the service was meeting the regulations we inspected.

Beverley Lodge Nursing Home provides nursing and personal care to up to 16 people, many of whom have dementia. At the time of our inspection 15 people were using the service.

One of the proprietors was the registered manager but was not based all the time at the service. They had appointed a person to manager the service on a day to day basis. They were in the process of being assessed by the Care Quality Commission to become the registered manager, and would take on this role once approved. 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. Throughout this report we refer to the registered manager as the 'registered manager', and to the person managing the service on a day to day basis as the 'manager'.

Medicines were stored securely at the service. However, we observed that medicines administration records (MAR) were not always sufficiently completed to reflect the medicines administered. We also observed some discrepancies in the stocks of medicines kept at the service. Safe medicines management processes were not consistently followed and there was a risk that people did not receive their medicines as prescribed.

Staff were knowledgeable about people's support needs. However, accurate and detailed records were not kept in regards to the support people required and the level of support delivered. People's care records, including confidential information, were not kept secure.

The manager undertook audits to review the quality of care provided. However, we observed that whilst the audits reviewed whether certain documents were in place they did not always comment on the quality of those documents. We also saw that where audits had previously identified concerns with medicines administration recording that sufficient action was not taken to address the issues.

The registered manager had not adhered to all the requirements of their registration and had not submitted notifications of the outcome of deprivation of liberty safeguard (DoLS) authorisations or in regards to all incidents that led to serious injuries. DoLS in a process of lawfully depriving a person of their liberty to maintain their safety and welfare.

An activities programme was in the process of being developed delivering one to one and group activities. However, people told us there often was not much to do and we did not observe many activities taking place at the time of our inspection. We recommend that the provider looks into national guidance to provide activities to engage and stimulate people with dementia.

There were sufficient staff to keep people safe and meet their needs. The manager regularly reviewed the staffing levels at the service as people's needs changed to ensure they were able to provide a timely service to people.

Staff had received training and had the knowledge and skills to support people. Staff received regular supervision and annual appraisals to discuss their roles and review their performance. Staff told us they felt able to speak with their colleagues and their manager if they needed any additional support or advice about how to meet people's needs.

Staff were knowledgeable about the people they were supporting. They were aware of the level of support they required and delivered this in line with people's needs and preferences. Staff liaised with other healthcare professionals when required to provide people with the additional level of care they required, including with their health needs and any dietary requirements. A GP regularly visited the service to review people's health needs and staff supported people to attend hospital if they had more serious concerns about people's health. Staff provided people with meals in line with their dietary requirements.

Staff were aware of the risks to people's safety. Assessments were regularly undertaken to review the risks to people's safety and staff supported people to minimise those risks. Action was taken in response to any incidents that occurred to ensure people's safety and to review the level of support people required as their needs changed.

Staff were aware of their responsibilities to support people in line with the principles of the Mental Capacity Act 2005. Where able, people were involved in decisions about their care and staff respected people's choices. Staff kept people informed and updated about the support they were providing and encouraged people to be involved, as much as possible, in their care needs.

People, their relatives and staff were asked for their views about the service, and were encouraged to feedback about their experiences. They were supported to make suggestions to improve the quality of the service and these were listened to.

We identified breaches of legal requirements in relation to safe care and treatment, good governance and the submission of notifications. You can see what action we have asked the provider to take at the back of the main body of the report.

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

Some aspects of the service were not safe. Safe medicines management processes were not consistently followed. We identified some stock discrepancies and gaps in medicines administration records, which meant there was a risk that people did not receive their medicines as prescribed.

The manager assessed the risks at the service and in the main managed those risks to ensure a safe environment for people. Staff were aware of people's risks to safety and plans were in place to minimise and manage those risks. Staff followed safeguarding adult's procedures if they had concerns a person was being harmed.

There were sufficient staff on duty to meet people's needs. Staffing levels were consistently reviewed to ensure there were appropriate numbers of staff on shift.

Is the service effective?

Good

The service was effective. Staff received regular training to ensure they had the knowledge and skills to support people. Staff's competency was reviewed during supervision sessions and staff were supported to develop their skills.

Staff adhered to the principles of the Mental Capacity Act 2005. They supported people to consent to their care. Best interests meetings were held when people had been assessed as not having the capacity to make care decisions. Staff adhered to the conditions detailed in people's Deprivation of Liberty Safeguards (DoLS) authorisations.

Staff liaised with other healthcare professionals to ensure people's health needs were met, and supported people with their dietary requirements.

Is the service caring?

Good

The service was caring. Staff treated people with compassion and respect. Staff maintained people's privacy and dignity.

Staff liaised with people, and their relatives, to identify people's

preferences and wishes. This enabled staff to provide care in line with people's choices. Staff kept people informed and involved in the care provided and respected their decisions in regards to the support they received.

Staff had spoken with people, and their relatives, to identify their end of life care choices, and advanced care plans were developed detailing people's choices.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive. Staff were knowledgeable about people's needs, however, accurate and complete care records were not maintained about people's care and support needs.

We observed that some activities were provided at the service, however, people told us there were not many activities on offer and we observed there were not many activities being delivered on the day of the inspection.

There were processes in place to listen to people's, and their relatives', views and opinions. The manager responded to any concerns or complaints made, and where required implemented the necessary action to address the concerns.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led. We saw that checks on the quality of the service were not sufficient to identify the areas we identified as requiring improvement on the day. Some improvements had been identified through the quality checking systems, but sufficient action had not been taken to address the concerns.

The registered manager did not adhere to the requirements of their registration, and did not submit all the statutory notifications they were legally required to do so.

Staff felt well supported by the manager, and felt able to approach them if they had any questions or concerns. Staff felt able to express their opinions and felt their views were listened to.

Beverley Lodge 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 took place on 1 February 2016 and was unannounced. An inspector undertook this inspection and the chair of the CQC board shadowed the inspection.

Prior to this inspection we reviewed the information we held about the service, including the statutory notifications received. Statutory notifications are notifications that the provider has to send to the CQC by law about key events that occur at the service. We also reviewed the information included in the 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.

During the inspection we spoke with five people and six staff including the manager. We reviewed five people's care records. We undertook general observations and used the short observational framework for inspection (SOFI) at lunchtime. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We reviewed records relating to the management of the service, including medicines management, audits, incident records and the staff team's training, supervision and appraisal trackers.

Requires Improvement

Is the service safe?

Our findings

Medicines were stored safely and securely, however, safe medicines management practices were not consistently followed. We observed that medicines administered were not always recorded on medicine administration records (MAR) and there were gaps in the records. People's MARs did not always accurately reflect the time that medicines were administered. For example, one person's MAR stated that a medicine was to be given at 8am, however on the day of the inspection this was given at 11am and the change in time was not recorded on the MAR. This could potentially impact on medicines that were required to have certain time intervals between doses. We also identified stock discrepancies and therefore there was a risk that people had not received their medicines as prescribed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulations 2014).

Checks were undertaken to ensure a safe environment was provided, including regular checks of gas safety, electrical safety and water safety. Environmental risk assessments were completed to identify potential risks to people's safety. However, we observed that the door to the laundry room was not always kept locked, and this posed a risk to people's safety due to the steep stairs to access the room. The manager told us this was an oversight on the day and staff were reminded to ensure the door was always locked. We also observed some equipment left in communal hallways that posed as trip hazards for people with limited mobility. We spoke with the manager about this and they said they would move the items causing a potential trip hazard. At the time of our inspection some of the call bells were not working properly. The manager informed us they were in the process of getting them repaired. In order to provide people with sufficient support when they were in their rooms, staff undertook regularly checks to identify if people required any support. For those people whose call bells were working, we observed that staff responded in a timely manner when people used the bell requesting assistance.

There were sufficient staff on duty to meet people's needs. The manager reviewed the staffing levels at the service and adjusted them as required to meet any changes in people's needs. There was a stable staff team who were familiar with the service and people's needs. The manager was in the process of recruiting staff to build up their bank team, so there were sufficient staff to cover annual leave, training and sickness. At the time of the inspection the service was using some agency staff to cover staffing leave. Regular agency staff were used to ensure consistency in care provision. One staff member told us there were enough staff to enable them to have the "time to look after people properly."

Staff were aware of their responsibilities to safeguard people from harm. Staff had received training on safeguarding adults and were aware of the reporting procedures to follow if they had concerns a person was being harmed. The manager liaised with the local authority safeguarding team about any incidents that led to a person being harmed or injured.

Staff assessed the risks to people's health and safety, and supported them appropriately to manage those risks. Preventative measures were in place to reduce the risk of people developing pressure ulcers. This included providing people with pressure relieving equipment and supporting people to reposition so that the pressure was redistributed to other areas of their body. People who were identified as at risk of falling

had mobility aids available. People who had limited mobility were supported to transfer including through the use of hoists and the support of two staff when required.

Staff supported people who were involved in incidents to ensure any further risks were minimised and people received the support they required with any injury they sustained. We saw that incidents were reported and reviewed by the manager to ensure appropriate action was taken at the time of the incident to support the person, and to ensure measures were put in place to reduce the risk of the incident recurring.

Good

Is the service effective?

Our findings

Staff had the skills and knowledge to support people. One staff member told us the training enabled them "to care for [people] to the best of our capability." They undertook regular training courses and updated their knowledge through annual refresher courses. This included training on fire safety, health and safety, moving and handling, safeguarding adults, infection control, and dementia awareness. Nursing staff also undertook training on medicines administration and catheterisation. Staff were supported to undertake additional qualifications including national vocational qualifications in health and social care.

Staff were supported through the completion of supervision sessions. Staff told us these supervision sessions gave them the opportunity to raise any concerns and have a discussion with their manager about any worries they had. The supervision sessions gave staff and their manager the opportunity to review their performance and to identify any additional support they required to undertake their role. Staff also received annual appraisals.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires 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 particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Staff were aware of their responsibilities and adhered to the principles of the MCA. People were involved in decisions about their care. When people did not have the capacity to make a decision, best interests meetings were held. Details were included in people's care records about any Lasting Power of Attorney's that were in place to make decisions on people's behalf. The manager had made applications to the local authority for authorisation to deprive some people of their liberty. Where DoLS had been authorised the details of the restrictions authorised were included in people's care records and staff were aware of these. This included supervising people in the community, having bed rails in place and seatbelts on wheelchairs.

People's health needs were met. One person told us the doctor had been to see them. There was a weekly visit from the GP to review people's health needs and staff told us the GP was available to come in-between these visits when required. Staff were aware of the signs and symptoms that indicated a person may have additional health needs. For example, if they had developed a urinary tract infection or if they needed additional support with their diabetes. Staff liaised with the nurse on duty and referred people to their GP or the hospital depending on the level of the health concern. Staff referred people to specialist healthcare professionals when required. This included referring people to a dietician if they were concerned that a

person was continuing to lose weight, and referring people at risk of choking to speech and language therapists.

Staff, including the kitchen staff, were aware of people's dietary requirements and the level of support people required at mealtimes. There were records in the kitchen informing staff about people's dietary requirements, including whether people required a soft diet, a low sugar diet due to their diabetes and any allergies people had. Staff were aware of people's likes and dislikes and used this information to develop the menu. We saw that the menu offered people two choices per meal. In addition, alternatives were available. For example, one person preferred cold food and smaller portions. They were provided with a sandwich at lunchtime instead of the main hot meal. They told us they enjoyed their sandwich and it had their favourite filling. Staff were aware of people's hydration needs and ensured people had regular fluids. We saw that people had access to cold drinks throughout the day and hot drinks were served at regular intervals. One person was enjoying a hot chocolate when we spoke with them in the afternoon. They told us it was their favourite and they often chose it instead of tea or coffee.

Good

Is the service caring?

Our findings

From the brief conversations we had with people they were able to tell us they were happy staying at the service and liked the staff. They told us they got on well with the staff and there were staff around to support them. They also said they were able to spend time doing what they wanted.

We observed staff speaking with people politely and in a friendly manner. During our observations at lunchtime we observed staff being attentive to people and offering to assist them with their meals. For example, offering to cut up their meat. We observed staff responding to people's needs promptly and providing them with the level of support they required. Staff were aware of people's preferences and likes.

Detailed information had been provided by people's families about people's interests, life histories and daily routines through the completion of 'This is me' documents. This detailed people's preferences in regards to the support they received. For example, the gender of the staff supporting them. This documentation also detailed how people communicated and what caused people anxiety. For example, one person did not like being left on their own for long periods of time. Staff used this information to provide care in line with people's wishes and ensured their choices were respected. Staff respected people's decisions about the day to day support they received and supported them to make those choices. For example, what they wanted to wear, what they ate and how they spent their time.

Staff discussed with people and kept them informed about the support they were going provide. Staff told us they tried to involve people in the support provided. This included informing them prior to providing support and ensuring support was provided at a time suitable for the person.

Staff respected people's privacy and maintained their dignity. Staff supported people to the toilet regularly and to change their clothes if they had spilt something down themselves to help maintain their dignity. Staff supported people with their personal care in the privacy of their bedrooms and the bathrooms.

Staff had received training on equality and diversity. They were aware of people's cultural and religious preferences. One person was supported by their family to meet their cultural needs, including providing Caribbean meals and maintaining their hair care. Staff supported the person to attend church and they had regular visitors from their church to undertake holy communion at the service.

Staff had discussed with people, and their families, their end of life wishes. Advanced care plans were in place detailing people's end of life wishes. This included their preferred place for care, and in what situations they would want to receive additional treatment. Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms were completed for people that did not wish to be resuscitated. 'Coordinate my care' forms were completed detailing people's support needs so there could be coordinated care when more than one health service was involved in the person's care or health needs.

Requires Improvement

Is the service responsive?

Our findings

Staff were knowledgeable about people's support needs and provided them with the care they required. Care plans were developed for each identified care need. However, we found that some care plans did not contain sufficient detail about people's needs and the level of support they required. As a result staff not familiar with an individual might not be able to fully understand how to meet their needs. For example, one person's communication care plan did not state that the person was partially deaf in one ear. Staff were aware of the support people required with moving and transferring around the service. However, some of the care plans we viewed did not contain sufficient level of detail about how this support was to be provided. For example, the records did not inform staff what hoist or size sling they needed to use to support people safely. Information from risk assessments were not always used to inform care plans. For example, plans on people's personal care did not always include the number of staff people required support from and care plans did not accurately reflect people's continence needs. We also identified that for one person who had a pressure ulcer that this was not mentioned in their skin integrity care plan. There was therefore no clear plan in place to guide staff how to manage and care for the pressure ulcer to promote healing.

We also identified that where care plans did detail the level of support people required it was not consistently recorded whether this level of support was being provided. For example, for people who were at risk of developing pressure ulcers it was recorded on the daily records that they were supported to reposition. However, it did not include the frequency that people were supported and records were not kept when people were being repositioned and therefore we could not be sure that people received care at the frequency required.

We found that accurate care plans that were personalised to each individual were not maintained and there was a risk that staff would not provide support that reflected people's needs. We also identified that care plans, including confidential information, were not stored securely. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulations 2014).

Nevertheless we did see that records were kept in regards to wound management. Staff liaised with the tissue viability nurse (TVN) to support people with their skin integrity. One person at the service had a pressure ulcer and staff liaised with the TVN as soon as they noticed the skin had started to breakdown. Staff were dressing the wound in line with advice provided by the TVN. We saw that the service used a recognised pain measurement tool to identify whether people were in pain and provided them with support they required, for example, in regards to their arthritis and wound management. We also saw that records were updated in response to incidents that occurred. For example, risk assessments and care plans were reviewed and updated in response to a person falling.

The activities coordinator was dedicated and passionate about their role. They had begun to develop the activities programme at the service. This included doing some one to one and group activities. We observed on the day of our inspection the activities coordinator was undertaking word searches with people and a film was on the television. From people's care records we saw that people had also been engaged in flower arranging, quizzes and pampering sessions. From speaking with people they told us they enjoyed the

pampering sessions and showed us their painted nails. However, people also told us there was not much to do at the service and they often got bored. One person said, "There's nothing to do." We observed that the majority of people spent the day in the lounge area but apart from the occasional one to one activity there was limited engagement and stimulation available.

A complaints process was in place. All complaints were investigated and dealt with by the manager. Where necessary, actions were put in place to address the concerns raised and reduce the risks of concerns recurring. This included liaising with other services providing support to people, for example staff at day centres people attended. The manager reviewed complaints to identify any trends. The manager discussed any patterns in concerns raised during meetings with people and their relatives.

We recommend that the service looks into national guidance for the provision of activities to engage people with dementia.

Requires Improvement

Is the service well-led?

Our findings

The manager undertook regular audits to review the quality of the service. However, we saw that some of these audits only reviewed whether items were in place and did not review the quality of them. The care records audits reviewed whether care plans and risk assessments were in place but did not pick up on the quality concerns and the missing detail we identified at our inspection. Medicines management audits were also conducted. Whilst they did review the completeness of the medicines management processes they had not identified the stock discrepancies that we found at the time of the inspection. The medicines audits had identified previous gaps on medicines administration records but sufficient action had not been taken to learn from these audits and ensure the quality of medicines management improved. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulations 2014).

The registered manager had not adhered to all the legal requirements of their registration. They had not submitted statutory notifications as required about a serious injury nor the outcome of applications for the authorisation to deprive people of their liberty. This was a breach of Regulation 18 of the Care Quality Commission's Registration Regulations 2009.

There was clear leadership and management at the service. Staff felt able to speak with the manager if they had concerns and also felt comfortable speaking with the registered manager. The registered manager managed the day to day running of the service if the manager was on leave or off sick. The manager told us they had a good working relationship with the registered manager and said they had regular contact with them.

Staff appreciated that the manager helped with nursing and caring roles, and we observed the manager supporting people on the day of our inspection. Staff told us the manager often supported them and offered advice if they had any questions about how to meet people's needs. The manager informed us they undertook a shift each week to ensure they were kept informed and up to date about people's needs. This included participating in the weekly GP round to discuss people's medical needs and any changes in their health.

All the staff we spoke with told us there was open and transparent communication within the staff team. They told us there was good teamwork and staff worked well together. Staff felt able to ask their colleagues and the manager for advice and guidance about how to support people. There was open communication in regards to any changes in people's needs so that appropriate support was provided.

People, their relatives and staff were asked for their opinions about service delivery and this was used to improve the quality of the service. Meetings were held with people and their relatives every three months. These meetings were used to discuss any changes at the service and to identify any additional support or activities people, and their relatives, wanted. The discussions had at these meetings were discussed at staff meetings to ensure all staff were updated about any requests or changes in people's support needs. There was an open session at each staff meeting, where staff were able to express their views, opinions and raise any concerns or suggestions they had to improve the support delivered.

The manager reviewed data held at the service to identify any trends and to take account of these on service delivery. This included reviewing data relating to falls, antibiotic use and hospital admissions to identify whether any improvements were required to service provision.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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	Regulation 18 Registration Regulations 2009 Notifications of other incidents Registered persons did not consistently submit notifications in regards to serious injuries and authorisations to deprive people of their liberty. Regulation 18 (1) (2) (a) (4A)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Registered persons did not ensure care and treatment was consistently provided in a safe way because proper and safe management of medicines was not in place. Regulation 12 (1) (2) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Registered persons did not ensure sufficient systems were in place to assess, monitor and improve the quality and safety of service provision. Regulation 17 (1) (2) (a) Registered persons did not ensure accurate, complete and contemporaneous records were kept of each service user was maintained. Regulation 17 (1) (2) (c)