Care Quality Commission

Country Court Care Homes 2 Limited

Lyle House

Inspection report

207 Arabella Drive
London
SW15 5LH

Date of inspection visit:
21 June 2018
26 June 2018

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27 July 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

We inspected Lyle House on 21 and 26 June 2018. This was an unannounced inspection.

At our previous inspection on 16 & 18 May 2017 we found the provider was not meeting regulations in relation to the outcomes we inspected, we found a breach of regulation in relation to Good Governance. At this inspection, we found the provider had met the breach we found at the previous inspection.

At the last inspection, the service was rated Requires Improvement.

At this inspection, the service was rated Good.

Lyle House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Lyle House provides personal care for up to 45 older people. The home is arranged over three floors and accommodates some people with a diagnosis of dementia.

There was a registered manager at the service. 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 had been with the provider organisation for a number of years. She had implemented changes which had been received positively by people, relatives and staff. The introduction of a care manager had led to improvements in a number of areas, including the relationship with external health professionals.

People and their relatives told us they felt safe at Lyle House. We received complimentary feedback about the caring nature of staff. Staff that we spoke with were aware of people's preferences in relation to their personal care and were respectful of peoples religious and cultural support needs.

People's needs were assessed before they moved into the home. Risk management plans, including ways in which the risk could be managed were in place. Care plans reflected people's individual needs and were reviewed on a monthly basis which helped to ensure people received the right support.

The provider managed people's support needs in relation to their medicines and general health. A GP visited the service on a regular basis and appropriate referrals were made to relevant professionals such as community nurses, psychologists and dietitians if people's needs changed and they needed specialist input.

People's consent was taken in line with the Mental Capacity Act 2005. Where people did not have the

capacity to consent, formal capacity assessments were completed and if required, decisions were taken in their best interests. The provider applied for lawful authorisation if restrictions were needed to keep people safe.

There were appropriate recruitment checks in place to ensure suitable staff were employed. These included reference and criminal record checks. There were enough staff employed to meet people's needs. New staff received appropriate induction training to prepare them for their jobs and regular refresher training was provided to al staff.

People were given information about how and who to complain to. Complaints were recorded and responded to in a timely manner.

There were systems in place to monitor the quality of service people received. A monthly reporting tool was used to monitor quality indicators such as falls, pressure sores, complaints and safeguardings. The registered and area managers undertook periodic audits that covered a number of areas including infection control, food quality, medicines and care planning. These were reviewed regularly and action taken in response to any concerns identified.

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 had improved to Good.

People received their medicines as prescribed.

Risk assessments included steps to manage the risk and these were proportionate to the level of risk identified.

People told us that they felt safe. Staff received safeguarding training and were aware of reporting procedures.

The provider had robust recruitment checks in place and there were enough staff to meet people's needs.

Is the service effective?

Good

The service had improved to Good.

Care workers received induction and ongoing mandatory training.

The provider was meeting the requirements of the Mental Capacity Act 2005 (MCA).

People were supported with regards to their health and received appropriate support in relation to their diet.

Is the service caring?

Good

The service had improved to Good.

People told us that staff were caring.

Care plans contained information related to people's preferences and cultural needs which staff respected.

Is the service responsive?

Good

The service had improved to Good.

The provider was responsive to people's needs which was reflected in the care plans.

Complaints were recorded and acted upon.

Is the service well-led?

Good

The service had improved to Good.

The provider had improved its working relationship with external health professionals.

The provider carried out a number of audits and the results were used to improve the service.

Lyle House

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.

We inspected the service on 21 and 26 June 2018. The first day of the inspection was carried out by one inspector, a specialist advisor and an expert-by-experience. The specialist advisor was a nurse. An expert-by-experience was a person who has personal experience of using or caring for someone who uses a residential service.

Before the inspection, we reviewed the information we held about the service. This included notifications sent to us by the provider and other information we held on our database about the service such as the Provider Information Return (PIR). Statutory notifications include information about important events which the provider is required to send us by law. A PIR is a form that requires providers to give some key information about the service, what the service does well and improvements they plan to make. We used this information to plan the inspection.

During the inspection we spoke with five people and two relatives to gather their views about the service provided. We spoke with the registered manager, the care manager, the area manager, the head chef and five care workers. We also spoke with two healthcare professionals who were visiting the service on the first day of the inspection.

We reviewed a range of documents and records including; six care records for people who used the service, four staff records, as well as complaints and compliments records and policies and procedures kept by the service.

Good

Is the service safe?

Our findings

People were protected from potential abuse and avoidable harm. People told us they felt safe in the presence of care workers and they were treated well. Relatives said they were reassured leaving their family members in the home. Comments included, "Yes, I believe they are safe from any intentional harm."

Training records showed that the provider arranged safeguarding training for staff which was refreshed regularly, this helped staff to be aware of safeguarding procedures. Staff that we spoke with were familiar with safeguarding procedures. One care worker told us, "Safeguarding is to protect our persons if any harm comes to them. If you notice anything you have to alert [the registered manager]. Neglect is when you do not care for the residents." Another care worker said, Safeguarding is protecting vulnerable people. First, I would report it to [the registered manager], or [the area manager] or CQC."

Where safeguarding concerns had been raised, these were recorded and the provider notified the appropriate external agencies. There was good management oversight into any safeguarding incidents which were reported and reviewed on a regular basis internally within the organisation. Incidents and accidents were recorded appropriately and post accident/falls observations were recorded. Any incidents/accidents were reported every month and analysed for any trends.

People told us care workers supported them to take their medicines on time and in a safe manner. They said, "I was on a lot of medication and now I'm down to one", "Yes staff help me and it comes on time." A relative said, "[My family member] takes a tablet in the morning. They follow all the correct procedures."

Policies were in place for the safe and effective use of medicines, including covert administration. We spoke with two staff about medicines management and they both had a good understanding of the policies and were able to gives us examples which demonstrated a good understanding of safe medicines management, including when to review medicines and when they would report any concerns to the GP.

All medicines were found to be stored appropriately, the drug fridge temperatures were recorded daily and staff had a clear understanding of what to do should there be an unacceptable temperature deviation. The medicines trolley was always locked when left unattended.

We observed a member of staff administering medicines to people using the service. They did this in a safe and appropriate manner. People were asked if they required their PRN (as required) medicines. If they refused, their decision was respected and they were not coerced. The staff member ensured people had water/juice to take their medicines with and observed people taking them. All Medicines Administration Record (MAR) charts were completed appropriately.

We discussed the checking and reconciliation of controlled drugs (CD) with staff and reviewed the CD record books which showed that CDs were consistently recorded. Staff had a good understanding of what to do should there be a discrepancy and were confident that any member of staff would be happy to report and inaccuracies.

The provider followed the principles of safer recruitment which helped make sure new staff were suitable to work with vulnerable people. Staff files included evidence of records checked to ensure that new staff were suitable for employment. This included their application form, references, proof of address, identity and right to work in the UK. Disclosure and Barring Service (DBS) checks were also completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

We found there were enough staff employed to meet people's needs. We asked people if there was always someone to help them if they needed assistance. They told us, "At the moment, I am able to carry on, but if you need them, they're there", "Most of the time", "Yes, you just press a button and they come, they are very good" and "Yes, they help me in the morning to wash myself."

People's level of independence in relation to a number of areas were worked out on a monthly basis. Each person was scored on their level of independence and how many hours of care they would need based on this assessed level. We reviewed the dependency tool which showed the actual allocated hours on rota were more than the dependency level calculated. The dependency tool was reviewed regularly by the area manager.

We reviewed staff rotas for the two weeks preceding our inspection, staffing levels were based on the dependency tool. There were nine care workers plus the care manager on each day shift and four care workers during the night. The staff levels were the same across the whole week, including weekends.

Risks to people's health and well-being were assessed and reviewed on a regular basis. Potential risks in relation to a number of areas were assessed, including communication, moving and positioning, personal hygiene, nutrition, pressure sores and falls.

The overall risk factor was based on probability and severity and the risk was assessed to be low, medium or high. Risk management guidelines was given, this was proportionate to the overall risk level. For example, one person was identified as a medium risk in relation to developing pressure sores. The guidance for staff stated the need for a foam mattress and profile bed, two staff to use a standing hoist, sliding sheet and the correct moving and handling technique. A pressure relieving cushion was also provided. We saw evidence of interventions and support provided, for example notifying the district nurses and completing body maps.

People had Personal Emergency Evacuation Plans (PEEP) which included details of any physical or sensory limitations that could have an impact on the evacuation procedures. They also included action to take and assistance methods required, such as the number of staff and any aids.

The maintenance engineer completed regular checks on equipment and the environment which helped to ensure this aspect of the service was safe. Health and safety checks on the staff call system, water temperatures, window restrictors, wheelchairs, shower chairs, moving and handling equipment and individual rooms were completed. A fire safety records book documenting periodic checks on fire safety systems including the fire detection system, emergency lighting and firefighting equipment was also maintained and up to date.

Service examination records for the hoists and slings, and up to date service reports and certificates for the fire detection and alarm systems, gas safety and firefighting equipment were seen.

The service managed the control and prevention of infection. Training records showed that 100% of staff had received training in infection control. Appropriate infection control measures were taken in the kitchen.

A kitchen diary was maintained, recording food delivery records, fridge temperature records and cooking and serving food temperature records. A daily and weekly cleaning schedule for the kitchen was in place. Food in the fridge was labelled with date opened and when it was to be used by and all food was stored appropriately. There were separate allocated areas for hand and pot washing, and for raw food preparation. This helped to minimise the risk of cross infection.

There was an infection control checklist for bathrooms and signs promoting hand hygiene were on display in bathrooms.

Audits in relation to infection control took place on a regular basis. An infection control audit took place in June 2018 assessing areas that included the kitchen, environment, waste disposal, linen, sharps, care of equipment, decontamination, hand hygiene, and clinical practice.

Good

Is the service effective?

Our findings

People using the service had their care and support needs assessed prior to moving into the service. Care records included copies of people's pre-admission assessments which helped to ensure their needs could be met by the provider. The assessment included details about people's health and well-being, and their level of independence in relation to a number of areas including communication, hygiene, food, continence, mobility and falls and medicines. The registered manager said people were able to come and visit the service prior to moving in and family or friends were often involved during the whole process.

New staff received an induction into their new role before they started employment. Induction training was completed in line with the Care Certificate was completed during this time. The Care Certificate is an identified set of 15 standards that health and social care workers adhere to in their daily working life. Induction training included an introduction to the service, the job role, going over important policies and procedures, and completing training in basic life support and moving and assisting. We saw some workbooks that recent, new employees had completed covering the topics within the Care Certificate.

Staff were appropriately supported through ongoing training, appraisal and supervision. Records showed that mandatory training was provided on a regular basis to staff which helped to ensure they were competent in those areas. Topics included safeguarding, Mental Capacity Act (MCA), fluids and nutrition, health and safety, infection control, dementia awareness, equality and diversity and person-centred planning. The training matrix for staff showed a high percentage of staff were up to date with their training.

The registered manager told us that additional training was available through the Clinical Commissioning Group (CCG) in specialist areas such as pressure sores and sepsis which they were always open to receiving. Care workers said, "I'm happy with the training. The last one I attended was fire safety. I had a supervision last week with [care manager]" and "The training is good but we have to come in on my day off sometime which I don't like." Records showed that staff had regular supervision meetings to discuss their roles. Staff said they found these beneficial.

The MCA provides a legal framework for making particular decisions on behalf of people who use the service and 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. We checked whether the service was working within the principles of the MCA.

Care plans included a section for memory and understanding which included a memory and understanding assessment. This was reviewed on a monthly basis and considered any behavioural, psychological and cognitive impact on people's mental capacity.

Mental capacity assessments were in place where it was felt that people did not have full capacity to understand decisions related to specific situations. Mental capacity assessments were seen for resuscitation, care planning agreement, personal care, medicines and safety checks.

The provider applied the two-stage test of capacity in order to decide whether people had the capacity to make a particular decision. Where people were not able to make decisions, there was evidence of best interest decisions, taken with input from relatives, friends or other significant people. A best interest decision record was kept for this.

A care worker said, "It's important to offer a choice, for example I will show them three blouses and allow them to choose." Another said, "If someone is not able to make a decision, we ask their families and get their views."

Where restrictions were in place to keep people from harm, the provider followed the principles of the MCA and applied for these restrictions to be lawfully authorised.

People and their relatives said that care workers looked after their general health. Comments included, "The GP comes regularly, you put your name down in a book", "[Relative] gets visits from the district nurses and things and I am going to ask the manager about going to the dentist."

People's medical conditions and medical history were recorded in care records. Care plans contained records of visits by health and social care professionals. There were also care plans in place to manage people ongoing health needs such as heart failure and diabetes. There was a minor ailments protocol in place, advising staff of what steps to take if people had minor ailments such as conjunctivitis, sore throat, vomiting, and rashes.

There was evidence that people had been referred to professionals in relation to their health needs. For example, some people had recently been to visit their optician and dentist. We also saw referrals to other professionals such as clinical psychologists for behavioural management advice.

The registered manager said they worked collaboratively working with external stakeholders. For example, there were regular visits from the rapid response team who provided clinical support and advice to prevent unnecessary ambulance call outs. We received positive feedback from health professionals about the openness of the service and the willingness of the registered manager and staff to work with them to provide joined-up care to people.

People and their relatives told us they were generally satisfied with the food at the service. Comments included, "It's okay, it comes on the dot. The food is a repeat performance", "It's not too bad, it comes on time. It could be better, it's simple", "It's lovely, no complaints, it's on time and there is a choice", "It's quite nice. The selection is nice" and "Very good it's not hard and made in small pieces. The food is well balanced and fruit is always around."

The head chef told us there was a four week menu cycle which was changed seasonally. Menus were sent down from head office and the head chef said they were given a bank of meals to prepare which helped them to prepare food that was nutritious. A cooked breakfast was available on request and the main meal was served at lunch. Meals were prepared in the main kitchen and taken up to the individual floors on heated trolleys. There was kitchen area on each floor stocked with snacks, bread and cereals from which care workers could prepare snacks for people outside of the dedicated meal times. Posters in the kitchen gave staff guidance on foods that were suitable for diabetics and also on good meal preparation and plate presentation.

Special dietary requirements, for example people who required soft food, those with allergies, diabetics were all listed on a noticeboard in the kitchen and the catering team were aware of their requirements.

People's personal dietary preferences and their likes and dislikes were recorded in their care plans, along with the level of assistance they required with eating and drinking. People told us if they needed support with food, staff helped them. Comments includes, "I need help with hard food, they cut my meat", "They support you if you want" and "I can eat on my own."

People's bedroom were clean, nicely decorated and personalised with their belongings. Decor was plain but still felt homely, with a good amount of natural light. Some paintings done by people were on display. Doors were wide and good for wheelchair users. Each floor had a communal lounge area and a small kitchenette in which people could socialise. There was also a separate lounge which doubled up as a space to provide group activities. People had access to an outdoor space on the ground floor which was well maintained.

Good

Is the service caring?

Our findings

People and their relatives said care workers treated them well and were kind and caring. Comments included, "They're very good, they tolerate and never get annoyed. They are excellent", "They are nice and speak nice", "They are all very nice I've never had any trouble", "I've not been here long, but they are very good, they've been marvellous" and "Brilliant. Every member of staff is so kind. Nothing is ever too much trouble." All of the people we spoke with and observed appeared happy and confident to speak openly about how they felt.

Staff respected people's choices. We observed the activities co-ordinator speaking with people in a gentle manner, encouraging them to attend activities and trying to persuade them but respecting their wishes when they refused to do so. Another person did not like being observed while taking their medicines; this decision was respected but the staff member did go back to check they had taken it. A care worker said, "[Person] is able to make choices about their personal care. I offer them a choice, if they refuse I return later or ask them."

We saw some caring interactions between care workers and people using the service. The activities co-ordinator was very engaging when giving manicures, speaking with people in a manner that demonstrated a knowledge of their past. Care workers were calm and patient when supporting people during lunch.

Care plans included a section called 'life story' which gave details about people's childhood, adulthood, significant relationships, places and events and other aspects that were important to people. Care records captured key information about people's personal preferences recorded in relation to personal hygiene and also any cultural and religious beliefs. This allowed care workers to be aware of people's diverse needs and so that care could be provided that meant their rights were respected. Staff received equality and diversity training and care workers were aware of people's individual needs. Care workers said, "We take them to the bathroom, make sure the doors are closed. You ask them for their permission. If they don't want you to wash certain areas you have to respect that" and "You respect people's religious and cultural beliefs."

There was a general noticeboard on display in the main reception area highlighting the wellbeing and dignity champions within the staff team. There was information about dignity & respect on display and how staff were expected to promote this within their roles.

People were supported to express their views and were involved in making decisions about their care and support and treatment. A food and menu survey was completed in May 2018, people were asked about choice, alternatives, presentation and the dining experience. Actions and areas of improvement had been identified following this survey. The registered manager also met with people and their relative outside of scheduled meetings to ensure the views of those who were not able to attend these meetings could be heard and acted upon.

Good

Is the service responsive?

Our findings

People received care that met their individual needs. Care plans in relation to a number of areas were in place and these were reviewed on a monthly basis which helped to ensure the appropriate level of support was provided to people.

People told us they, or their family members had been involved in planning their own care. They said, "I have [family members] who arrange meetings and take care of this" and "Yes they do consult you and you can look at it whenever you want."

Good practice was evident that demonstrated the provided was responsive to people's changing support needs. For example, a Malnutrition Universal Screening Tool (MUST) assessment to assess the risk of malnutrition had been completed for a person who was losing weight. In response, the provider had made a referral to the dietician and the care plan updated accordingly. Another person who was diabetic, was referred to the dietician. Staff were aware of suitable food for this person and followed guidance as stipulated by the dietitian in supporting them to eat appropriately. A care plan linked the administration of insulin and the need to ensure appropriate nutrition throughout the day to avoid fluctuations in blood sugar levels which could be a contributory factor to falls. A falls risk assessment had been completed with appropriate care plans in place to monitor this.

Information was recorded about people's preferred routines, providing guidance to staff about how they liked to be supported in relation to their food and personal care. Daily care and support records were in place which included care monitoring, details of personal care delivered, whether people at risk of sores had been repositioned. ABC charts to record information about particular behaviours and sleep charts were used. These were requested by external health professionals following referrals from the service.

There was a care plan in place for social interaction, engagement and meaningful opportunities and risk assessments for social isolation. Records of social activities, both 1:1 and group activities that people had taken part in were recorded. One person said, "There's hairdressing and other things, always something going on."

There were two activity co-ordinators employed, we observed one who engaged very well with people. There was a board on display with a list of daily activities on offer but this was flexible and subject to change. The activities were customised to the preference of the people who wanted to take part.

People and their relatives we spoke with knew who to contact if they were unhappy. Comments included, "Yes, I would speak to the manager" and "You would only have to speak to the supervisor." A poster on how to raise and escalate a concern was on display in the reception area along with a complaint form.

There were appropriate systems in place to receive, respond and act upon complaints. A complaint register was maintained with details of the complaint, the person overseeing the investigation, details of the investigation report date and the outcome. There had been 12 recorded complaints in the past year, we saw

that these had been investigated thoroughly, for example by speaking with relevant people and staff and checking records. Feedback was provided to complainants and if appropriate and action plans to make improvements had been implemented.

Good

Is the service well-led?

Our findings

At our previous inspection which took place on 16 & 18 May 2017, we found the lack of a long standing registered manager had resulted in some aspects of the service not being well managed. The provider's own quality monitoring processes had not identified ongoing issues we identified during the inspection.

At this inspection, we found improvements had been made. The provider was now meeting the regulation.

There was a registered manager at the service. 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 and associated Regulations about how the service is run.

People using the service told us the service was good, comments included "Excellent. The way they cope with everything they're very organised", "I feel like it's a good home", "Very good, I think the girls [staff] are good at what they do" and "I'm very pleased".

The provider had recently recruited a care manager to oversee the clinical practice and care planning within the service. We spoke with the care manager who demonstrated a commitment to improve and acknowledgement that the home and the staff were on a journey. They said their recent focus had been on improving the working environment and culture within the service. Examples were given such as introducing two monthly weekly formal supervisions, providing hands-on care, working alongside staff during medicines rounds and delivering a workshop focusing on culture change to staff.

The registered manager and care manager had also worked on improving and building relationships with external agencies. The care manager had started to accompany the GP on all their rounds to enable closer working. The had improved communication with local pharmacist and were open to visits from community nursing team.

Healthcare professionals said, "The relationship has been really good, I can rely on them to call me" and "I feel they are working in the right direction." They also said the home was more proactive in working with them and said they were involved in some joint projects with them. One of which was doing more regular baseline observations so any early warning signs could be identified and sent to the GP and other health professionals in a timely manner.

Team working within the staff team had improved by rotating staff between floors on a weekly basis, except for seniors who were the first point of contact on each floor. Staff were positive about this recent change in rotating shifts and reported that this contributed to good team working. Care workers told us they felt supported. Comments included "They (management team) do support us", "[The registered manager] and [Care manager] are supportive and approachable" and "Bringing [Care manager] as the care manager has been a positive step."

There were systems in place to check the quality of service provided to people. Monthly visual kitchen and 'front of house' checks to place, a food and menu survey was completed in May 2018. Weekly and monthly medicines audits were completed by the care manager and area manager. An external pharmacy audit was completed in May 2018. There was a corrective action report to make improvements to some areas of medicines practice following this audit.

The area manager was a visible presence in the home and carried out provider visit checks looking at different experiences of care, covering care plans, medicines, environment and dining room experience. The operations director did a full provider visit in June 2018 looking at all key questions of the CQC methodology.
Any identified areas of improvement following these audits were discussed at relevant meetings.

Staff were able to contribute their ideas through a number of meetings. These included Flash meetings which took place on a regular basis every few days involving seniors from each floor and a representative from each department. These meetings was used to discuss issues relevant to each department and any important notices and updates. General staff and senior staff meetings took place, with separate meetings for night staff.

Meetings for people using the service and their relatives in which they were asked if they were happy with the care, the food and the activities provided took place. The feedback was positive. The registered manager also met with relatives that were unable to attend meetings, when they came to visit their family members to ensure their views were taken into consideration.

A Quality Indicator (QI) report was generated and submitted to the area manager every month. This was a report of a number of indicators such as of pressure sores, infections, deaths, safeguardings, complaints, accidents/incidents and staff development and recruitment. Following the report, meetings were held to discuss any anomalies in more detail and what could be done to prevent them in future.