Majesticare (Lashbrook) Limited

# Lashbrook House

## Inspection report

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Date of inspection visit:
31 March 2016

Date of publication:
05 August 2016

## 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? | Requires Improvement |
| Is the service well-led? | Good |

# Summary of findings

## Overall summary

We carried out this inspection on 31 March 2016 and the inspection was unannounced.

Lashbrook House is a care home providing accommodation for people requiring personal and nursing care. The service supports older people with a variety of conditions which includes people living with dementia. At the time of our visit there were 36 people living in the service.

The service had a new manager who had submitted their application to CQC to become the 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 manager was passionate about providing high quality care and was looking at ways to improve the service. A schedule of works had been developed to improve the environment and works were underway when we visited. Where concerns were raised in relation to the quality of care, the manager took prompt and effective action to address issues.

People were positive about living at Lashbrook House and the kindness of staff supporting them. People enjoyed the food and were offered a choice at every meal.

Throughout the inspection there was a cheerful atmosphere and we saw many kind and caring interactions. People were engaged in activities and enjoyed a musical entertainer during the afternoon.

People's needs were assessed and care plans developed to identify how people's needs would be met. Risks to people were identified, however risks were not always managed. Specialist equipment was not regularly monitored to ensure it was being used in line with manufacturers guidance.

Staff felt supported and valued. Staff received regular supervision and training to ensure their skills and knowledge were up to date. Staff understood their responsibilities to identify and report concerns relating to safeguarding vulnerable people. People were supported by staff who understood the principles of the Mental Capacity Act 2005 (MCA). Staff were kept up to date with people's changing needs through daily meetings. However, staff did not always support people in line with guidance in their care plans.

The manager sought people's views about the service through regular meetings. Questionnaires had been sent out to seek feedback about the service and look for ways to continually improve.

There were effective quality assurance processes in place to monitor and improve the service.

## 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.

Risks to people were identified and plans were in place to manage risks.

Staff understood their responsibilities to identify and report any concerns relating to the abuse of vulnerable people.

People's medicines were managed safely and people received their medicines as prescribed.

### Is the service effective?

Good

The service was effective

People were supported by staff who understood the principles of the Mental Capacity Act (2005).

Staff felt well supported and had access to training to ensure they had the skills and knowledge to meet people's needs.

People had food and drink to meet their dietary needs. People enjoyed the food and drink offered.

### Is the service caring?

Good

People were supported by staff that were caring.

Staff had developed meaningful relationships with people.

People were treated with dignity and respect. Staff respected people's choice and explained clearly before supporting people.

People were involved in decisions about their care and decisions were respected.

### Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not always supported in line with their care plan.

People enjoyed a variety of activities and were positive about the activity coordinator.

People knew how to make a complaint and were confident to do so.

## Is the service well-led?

Good

The service was well led.

Quality assurance systems were effective.

The manager had a person-centred approach and ensured that people were at the centre of everything they did.

Staff were positive about the manager and felt improvements were being made.

# Lashbrook 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.

This inspection took place on 31 March 2016 and was unannounced.

The inspection was carried out by 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.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at notifications received from the provider. A notification is information about important events which the provider is required to tell us about by law.

During our inspection we carried out a 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 also observed care practices throughout the day.

We spoke with 13 people who used the service and two visitors. We looked at seven people's care records, six staff files and other records showing how the home was managed. We spoke with the manager, two nurses, and four members of the care team, the chef and the activities coordinator.

Good

# Is the service safe?

## Our findings

People told us they felt safe. One person said, "Yes of course". when asked if they felt safe. Another person told us they felt safe because, "I don't have to worry about things they will sort them for me".

People's care records contained risk assessments and where risks were identified care plans were in place to state how the risks would be managed. However where care plans identified measures to reduce risks these were not always being followed. For example, four people's care records showed they were assessed as at high risk of pressure damage. Care plans stated the people required specialist mattresses tor educe the risk of skin damage. We saw people had specialist mattresses in place; however three of the mattresses were not set at a pressure appropriate for the person's weight. Records showed the pressure in the mattresses had last been checked on 9 February 2016. We spoke to the manager who took immediate action to check all pressure mattresses and told us they would ensure all mattress pressures were checked daily following the inspection.

Staff had received training in protection of vulnerable people. Staff understood their responsibilities to identify and report any concerns relating to abuse. Staff told us they would report concerns to the manager and were confident that issues would be taken seriously and action taken. Not all staff were aware of the outside agencies they could report to if they felt the organisation had not taken action. Some staff told us they would report concerns to the Care Quality Commission (CQC). We spoke to the manager who told us they would arrange training updates for staff to ensure they understood their responsibilities to report their concerns.

Medicines were administered safely. There were procedures in place to record the receipt, administration and disposal of medicine. People's medicine administration records (MAR) included photographs of each person and details of allergies. MAR were completed accurately and where there were hand written entries these had been signed and witnessed to reduce the risk of errors. Records relating to the administration of topical medicines were kept in a separate folder and were completed when the medicine had been applied. Records included body maps to indicate where the medicine was to be applied. Topical medicines are applied to the skin, for example creams and ointment.

Where people were prescribed medicines to be given as required (PRN), there were protocols in place detailing when PRN medicines should be given, the dose, frequency and why the person required the medicine. People received their PRN medicines appropriately. For example, a nurse asked a person if they were experiencing any pain and offered pain relief. This followed the guidance on the PRN protocol.

Nurses were responsible for the administration of medicines and followed safe practices when administering. The nurse observed people taking their medicines before leaving them and signing the MAR.

Medicines were stored in a locked trolley and the keys were held by the nurse responsible for the administration of medicines. The temperature of the medicines storage room and medicines fridge were monitored and recorded daily. Temperatures were within the recommended levels to ensure medicines

were stored safely.

People told us there were enough staff and that call bells were answered promptly. One person said, "Most of the time it's pretty good, but if it is a really busy time then it may take a few minutes".

Staff told us there were enough staff working in the home. One member of staff told us, "We have enough, unless there is sickness and then [manager] does her best and calls agency". During the inspection we saw that call bells were answered in a timely manner and people's requests for support were responded to promptly.

The manager used a dependency assessment tool to determine the number of staff required to meet people's needs. The assessed number of staff were available for the six weeks rotas we looked at.

People were complimentary about the cleanliness of the home. One person said, "The place is really clean and never smells. They come in to my room and clean that too". Staff used protective equipment when needed and good practice in relation to infection control was followed.

Good

# Is the service effective?

## Our findings

Staff had received training in the Mental Capacity Act 2005 (MCA) and had a good working understanding of the principles of MCA. 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. One member of staff said, "It's about choice; you ask them (people), show them and explain about it. If they refuse you try again. Sometimes you have to wait a few hours and be patient. We have to be ready to catch the moment, you cannot force anybody".

The manager had a clear understanding of their responsibilities in relation to Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). People's care plans contained mental capacity assessments to determine whether people had capacity to consent to living in the home. Where people were assessed as lacking capacity to consent the registered manager had considered DoLS applications to ensure that anyone being deprived of their liberty to receive care and treatment this was in their best interest and was legally authorised.

Care plans identified areas of people's care where they lacked capacity to consent. For example, care plans identified people lacked capacity to consent to bed rails. However, there was not always a record of a capacity assessment to support the care plan.

New staff received an induction when starting work in the home. One new member of staff told us, "There were lots of DVD's and lots of questions asked. You had to get them right to pass". Training included moving and handling, fire safety and dementia. New staff also worked alongside more experienced members of staff before working alone. Staff told us they received regular training updates to make sure they kept their skills and knowledge up to date. For example, one member of staff told us they were booked to attend some training in dementia care.

Staff felt supported and received regular supervision. One member of staff told us, "I feel very supported. Supervision makes me feel strong, [manager] is so encouraging".

Regular staff meetings and daily handovers ensured staff were kept up to date about people's changing needs. One member of staff told us, "We have a group meeting in the morning with the nurse; a handover. Carers also tell nurses about any problems they may have".

People were complimentary about the food they received. One person told us, "The food here is absolutely beautiful, sometimes the portions can be a little big but they don't grumble [if food is left over] as long as we're eating enough".

People received food and drink to meet their nutritional needs. Where people had specific dietary requirements these were identified in people's care plans. For example, one persons' care plan stated the

person required thickened fluids and a soft diet. We saw the person received food and fluids in line with their care plan.
Where people were identified at risk of malnutrition food and fluid intake was monitored. Charts were completed and people's fluid intake was totalled daily and monitored to ensure they were receiving sufficient fluids. The chef told us they were made aware of anyone at risk of malnutrition and provided a fortified diet for those people. Fortifying food included adding butter, cream and cheese to food to increase the calorie content.

People were offered a choice of meal and were shown the plated meals to enable them to make an informed choice. If people did not like what was on offer the chef would prepare an alternative. One person said, "If I don't like what is on the menu they will make me something else. Something I like instead. Nothing is too much trouble for them".

People were able to choose where they wished to eat their meals and received support to eat and drink where they chose. For example, one person was in the lounge area and told a member of staff, "I think I would prefer my room please". The member of staff respected this decision and supported the person to return to their room for the meal. People were supported to eat and drink at their own pace and staff sat with people throughout the meal.

People had access to health professionals where needed. We saw people had accessed G.P's, chiropodists, speech and language therapists, physiotherapists and community psychiatric nurses. Where recommendations had been made these were detailed in people's care plans and recommendations were followed.

Good

# Is the service caring?

## Our findings

People were positive about the caring nature of staff. Comments included: "I really like it here, the staff are so kind, nothing is too much trouble"; "It's just like a big family here, everyone looks out for each other" and "People (staff) are very good. They look after me very well".

Throughout the inspection people were treated in a kind and compassionate manner. Staff spent time with people and used their knowledge of people to talk with them. For example, one person was greeted by a member of staff who complimented the person on how they looked. This person's care plan stated the person liked to be dressed smartly.

People had developed positive relationships with staff. For example, one person was brought into a communal area by a member of staff. Other staff present smiled and greeted the person by name, asking how they were. The person smiled and clearly enjoyed the interaction.

Staff supported people in a calm and reassuring manner when people displayed behaviour that indicated they were anxious. For example, one person was trying to stand and was becoming anxious as they were unsteady on their feet. The person was reluctant to accept support from staff; the member of staff supporting the person spoke calmly explaining what was going to happen and showing empathy that the person was cautious, reminding them they had been unwell.

Staff included people in conversations at every opportunity. For example one member of staff was talking to a member of the inspection team. The member of staff ensured the person felt involved and explained what they were speaking about.

People were treated with dignity and respect. One person was in a communal area of the home and was attempting to take off their clothes. A member of staff immediately approached the person and explained they would be cold if they took their clothes off. The person became anxious. The member of staff called a colleague in a discreet manner and asked them to assist. One member of staff held a blanket in front of the person while the other member of staff spoke with the person, distracting them and supporting them to put clothes on. A member of staff then sat with the person ensuring they remained calm.

Staff had received training in equality and diversity and understood their responsibilities in relation to protecting people's human rights. People were respected and staff did not discriminate against people as a result of their cultural or sexual preferences. One person's first language was not English. A member of staff who spoke the person's first language chatted to the person and it was clear they both enjoyed the interaction.

Care plans showed that people had been involved in developing their plans and where appropriate family members had been consulted. Throughout the inspection we saw that people were included in decisions about their care and decisions were respected.

Requires Improvement

# Is the service responsive?

## Our findings

People were assessed prior to admission to the home. The assessment was used to develop a person-centred care plan. Care plans included people's life history, likes and dislikes, communication needs and well-being needs. For example, one person's care plan detailed that they enjoyed music and dancing. The care plan identified the person could become anxious and stated, 'I will settle down if somebody will sit near me and speak with me'. Throughout the inspection we saw staff stop and speak with the person each time they were nearby and on one occasion a member of staff danced around the communal area with the person, the person enjoyed the interactions and smiled when dancing to music.

However, people were not always supported in line with their care plan. One person's care plan identified, 'I am quite deaf and blind so can become afraid. I want people to approach me slowly and calmly'. This person was sat in a communal area of the home and was calling out. Staff entered the room but did not approach the person or offer any reassurance. One member of staff called across the communal area to the person. "Open your eyes please". The person did not respond to this interaction and continued to call out and started to become anxious. A nurse entered the communal area and immediately approached the person touching them gently on the arm. The nurse spoke to the person calmly and the person stopped calling out. The nurse sat with the person reassuring them.

Care plans detailed people's physical care needs. Care plans were regularly reviewed and updated when people's needs changed. For example, one person had developed a small skin break, the care plan identified that as a result the person required their position to be changed two hourly. Records showed the person's position had been changed in line with the care plan and the wound had healed.

People and relatives were positive about the activity coordinator. One relative told us they (the activity coordinator) were "Very good at involving residents".

The activity coordinator arranged a variety of activities that took place in the home. Group and individual activities were organised. During the morning, the activity coordinator spent time with a group of people reminiscing. The activity coordinator ensured that everyone joined in the conversation and included people who were sat away from the group enjoying a painting activity. Everyone who participated in the reminiscence responded positively when asked if they had enjoyed the activity. One person said, "You (activity coordinator) make it sound so interesting".

During the afternoon an entertainer visited the home, 17 people enjoyed listening to the music. People were singing along and tapping their feet to the music. Staff supported several people to dance.

People walked freely around the home and had many meaningful interactions with staff as they passed. Staff asked, "Are you OK" and "Do you need any help".

The manager told us a second activity coordinator was being employed to increase the amount of activities on offer and to improve the activities for people who did not enjoy group activities.

There was a complaints policy and procedure in place. These were displayed in the entrance to the home. People knew how to make a complaint and were confident to tell the registered manager if they had any issues. All complaints were recorded and had been responded to in line with the organisations complaints policy. Compliments were also received and shared with staff.

Good

# Is the service well-led?

## Our findings

The manager had recently been appointed and had applied to CQC to become the registered manager. People and their relatives were complimentary about the manager. People were positive about the changes the manager had implemented and those being planned. Several areas of the home were being refurbished to improve the environment for people living with dementia. The manager spoke passionately about the home. A clear action plan had been developed to identify the improvements and when they would be completed.

Staff were extremely complimentary about the manager. Comments included, "[Manager] is good; she really tries to improve things"; "I think [manager] is a good manager. I trust her and I know she will help me if I have a problem"; "The manager is very, very clear with staff. You can go and see her any, with any problem" and "We are quite well supported and I enjoy my work here, the residents are lovely, I like coming to work".

Staff were aware of the whistleblowing policy and felt confident that the manager would ensure any issues or concerns were addressed.

The manager promoted a person-centred approach to care and ensured that people were at the centre of everything that happened in the home. When care was not of a high quality the manager took immediate and appropriate action to address concerns. For example, an issue was reported relating to procedures being used by staff who were supporting a person to move. The manager took immediate action to ensure people were safe. The manager checked that staff involved had received appropriate training and supervision and took steps to investigate the incident.

The manager held regular meetings with people and their relatives. The meetings enabled people to be kept informed of any changes in the service and for the service to seek feedback in relation to any improvements identified. Records showed the manager had shared information relating to a monitoring visit carried out by the local authority and the planned refurbishments of the home. People had given positive feedback about the nursing staff at the meeting and nurses we spoke with were aware of the feedback.

Regular staff meetings were held and included meetings for heads of department, nurses and care staff. Staff were positive about the meetings and felt they were listened to. A recent meeting identified the manager had given positive feedback to staff and had thanked them for their support. The meeting had included a discussion about the areas a CQC inspection would look at and raised awareness with staff.

There were regular auditing systems in place which included audits of: maintenance; medication; pressure care management and care plans. Where issues were identified an action plan was in place to address the issues.

Accidents and incidents were recorded and monitored to look for trends and themes. For example, where people experienced falls, actions were taken on an individual basis to reduce the risk of further falls. The system also tracked the times of falls to enable the manager to look for any trends that may indicate any

issues at specific times of day.

The service had recently sent out surveys to people and their relatives and at the time of our inspection some responses had been received. The manager advised us that the results of the survey would be collated and an action plan developed to ensure feedback was used to improve the service.