Avery of Leicester (Operations) Limited

South Lodge Care Home

Inspection report

307 London Road
Leicester
Leicestershire
LE2 3ND

Tel: 01162748000
Website: www.averyhealthcare.co.uk/care-homes/leicestershire/leicester/south-lodge/

Date of inspection visit:
05 March 2019

Date of publication:
20 May 2019

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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service: South Lodge Care Home is a care home that provides nursing, personal care and accommodation for up to 106 older people. Accommodation is arranged over four floors, in four distinct units. People had individual apartments with wet rooms and, in some cases, kitchenettes. At the time of our inspection, there were 93 people using the service.

What life is like for people using this service:
•Staff were not always effectively deployed in the service to ensure people received support and assistance in a timely manner. The manager was in the process of taking action to mitigate risks for people and ensure sufficient numbers of staff were always deployed to meet people's needs.
•Staff were not always clear in their day to day roles and responsibilities. People, relatives and staff felt able to share their views about the service but were not always confident action would be taken to make required improvements.
•The provider undertook a range of quality audits and checks which helped to monitor the quality of the service provided and identify where improvements were required. Records did not always clearly demonstrate timescales for improvements or if improvements had been actioned.
•Staff understood their role to safeguard people from the risk of abuse and manage risks associated with people's care and support.
•People received their medicines safely; lessons had been learnt from recent medicine errors. Staff followed procedures and guidance to prevent and/or reduce the risk of infections and cross infection for people.
•Staff were safely recruited and had completed relevant training to give them the skills and knowledge they needed to meet people's needs.
•People's needs were assessed before using the service and this information was used to develop care plans.

•People were supported to eat and drink healthily and reduce the risk of poor nutrition. Staff supported people to access the healthcare they needed to maintain their well-being.
•People were supported to have choice in their daily lives and staff supported them in the least restrictive way possible.
•People were treated with kindness and respect. People and their relatives were supported to express their views and make decisions about the care they received. Staff promoted people's independence and respected people's right to privacy and dignity.
•People received personalised care from staff who followed detailed guidance in people's care plans. People were able to participate in a range of meaningful activities.
•People and relatives knew how to raise concerns and complaints about their care.
•People were supported to receive end of life care in line with their wishes and preferences.
•The manager was clear on their responsibilities and demonstrated a commitment to ensuring people receiving quality, good care.

Ratings at last inspection: This was the first inspection under the new provider; the service had previously been rated as Good.

Why we inspected: This was a scheduled inspection.

Follow up: We will continue to monitor the quality of the service through the information we receive until we return to visit as per our re-inspection programme. If any information of concern is received, we may inspect sooner.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not consistently safe. Details are in our Safe findings below.	**Requires Improvement**
Is the service effective? The service was effective Details are in our Effective findings below.	**Good**
Is the service caring? The service was caring Details are in our Caring findings below.	**Good**
Is the service responsive? The service was responsive Details are in our Responsive findings below.	**Good**
Is the service well-led? The service was not consistently well-led Details are in our Well-Led findings below.	**Requires Improvement**

South Lodge Care Home

Detailed findings

Background to this inspection

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

Inspection team: This inspection was carried out by two inspectors, a specialist clinical advisor who was a nurse and two experts-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.

Service and service type: South Lodge Care Home is a care home. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a registered manager in place at the time of our inspection. An experienced manager was in post and had started the registration process. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of the inspection: This inspection was unannounced.

What we did: We reviewed information we had received about the service since the last inspection in June 2016. This included details about incidents and events in the service that the provider must notify us about by law. We asked the provider to complete a Provider Information Return prior to this inspection. This is information we require providers to send us and gives some key information about the service, what the service does well and improvements they plan to make. We also contacted local authority commissioners, responsible for funding some of the people who used the service, to gain their feedback on the service.

During the inspection we spoke with 11 people using the service and nine relatives to gain their views on the care provided. We spoke with the manager, the regional manager, seven care staff, two nursing staff and a housekeeper.

We reviewed a range of records. These included seven people's care records, medicines, accidents and incidents, complaints and minutes of meetings. We also looked at four staff recruitment files and records relating to staff training. We reviewed records relating to the management, quality and safety of the service.

Following our inspection, we asked the provider to send us further information relating to quality assurance and key policies. They sent this to us in a timely manner.

Requires Improvement

Is the service safe?

Our findings

Safe - this means we looked for evidence that people were protected from abuse and avoidable harm

People were not always safe and protected from avoidable harm.

Staffing and recruitment:
•People, relatives and staff shared mixed views on whether there were always sufficient numbers of staff available to meet people's needs.
•Two comments from people described staff as responsive to calls for help, whilst comments from other people and relatives described extensive delays in people receiving the help they needed. In particular, timely assistance with personal care and medicines.
•One person described how, on days when staff were rushed, they attended the person's apartment to switch off the nurse call but did not provide assistance, explaining they were unable to help until later.
•Two relatives told us they had supported their family member to get up, washed, dressed and provided them with breakfast as they had arrived mid-morning and found the person in bed, still waiting for assistance. They told us this was not the first occasion they had had to provide this support in recent weeks due to lack of available staff.
•Staff told us they felt rushed and, at times, staffing levels were not sufficient to meet people's needs and keep them safe. Comments included, "This is not person centred, relatives are complaining because care is being given late," "I can't get to residents in time," "I go home and worry that I have missed something because we are so busy," and "Residents are complaining because they are getting up late and having their breakfast late."
•We observed there were sufficient numbers of staff to meet people's needs in two of the four units in the service. Nurse calls were answered in a timely manner and staff were attentive to people.
•However, in the other two units, we saw people had to wait for the care and support they needed. For example, one person had waited over one hour for medicines that should have been administered by a specific time. The person was frustrated and anxious at the delay. Three relatives walked corridors looking for staff to assist their family member's in their apartments but were unable to locate any available staff.
•The manager told us staffing levels were calculated based on people's dependency levels and staff deployment was flexible within the service. For example, if there was a low need for staff on a particular day in one unit, a staff member was assigned to another unit to provide additional support.
•The manager told us there had been a turnover in staffing following a recent change in provider, but these posts had been recruited to and new staff were attending induction training.
•Staffing rotas were managed by senior staff on each individual unit, with the manager having an oversight through electronic monitoring.
•Following our inspection, the manager sent us details of action they had taken in implementing new systems of working and monitoring relating to staff deployment. They told us they would review and analyse this weekly to assess the impact of the changes in ensuring sufficient staff were always deployed to keep people safe and meet their needs in a timely manner.
•Safe recruitment processes were in place that helped to ensure only suitable staff were recruited by the service.

• Appropriate pre-employment assessments and checks had been carried out. These included Disclosure and Barring Service (DBS) checks and proof of identify.

Systems and processes to safeguard people from the risk of abuse:
•Staff knew how to recognise signs of abuse and were clear on how to report concerns, including raising concerns of potential malpractice outside of the service.
•Staff told us they had completed training in safeguarding and records confirmed this.
•The manager understood their responsibilities in relation to safeguarding and had made appropriate safeguarding referrals.
•The manager liaised with external agencies to ensure potential safeguarding incidents were investigated which helped to protect people from discrimination and reduce the risk of further incidents.

Assessing risk, safety monitoring and management:
•Where there were identified risks to people, assessments had been completed and measures identified that would reduce the risk wherever possible.
•Risk assessments in people's care plans were detailed and explained how staff should support people safely.
•Staff knowledge reflected what was detailed in people's risk assessments. For example, where a person was at risk of falling from bed, staff had ensured crash mats and sensor mats were in the correct place and the bed was on the lowest setting. A second person was at risk of developing sore skin and staff were aware of the signs that may indicate intervention was required. This had prevented the person developing sore skin.
•Staff knew how to comfort people and reduce people's anxiety to reduce the risk of people displaying behaviours that challenge. Care plans included guidance for staff to follow and included appropriate interventions and potential triggers.
•Assessments were in place to guide staff on the support people needed to stay safe in the event of an emergency, such as fire.

Using medicines safely:
•There were safe practices in relation to the storage and disposal of medicines.
•Staff had received training in how to administer medicines which included observations of their competency.
•People's care plans included a description of the support they needed to take their medicines and how they preferred this to be provided. We saw staff followed this guidance.
•Medicines records were completed and regularly checked to ensure these were accurate. The manager had undertaken audits of medicine records and identified improvements were required following recent medicine errors and gaps in recordings; action had been taken to make the required improvements.
•There were systems in place to ensure medicines which were to be taken as and when required or disguised in food and drink, were administered safely and in line with clinical guidance.

Preventing and controlling infection:
•There were effective measures in place to ensure the risk of infection and cross contamination were prevented and/or minimised.
•Staff were provided with and wore personal protective equipment, such as gloves and aprons, and these were changed between tasks.
•Housekeeping staff demonstrated a good understanding of cleaning schedules and measures they needed to take to reduce the risk of infection.
•The premises were clean and well maintained.

Learning lessons when things go wrong:
•The manager had analysed accidents and incidents that had occurred and used this information to reduce the risk of further harm for people.
•For example, falls were analysed to identify what measures were needed to reduce the risk of further falls, or if existing measures were effective.
•Staff understood how to report incidents and accidents that occurred within the service.

Good

Is the service effective?

Our findings

Effective - this means that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

People's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs, choices; delivering care in line with standards, guidance and the law:
•People's needs were assessed before they began to use the service, and people and relatives were involved in deciding how they wanted their care to be provided.
•Assessments included people's needs and wishes in relation to lifestyle choices, religion, relationships, culture and diet.
•Staff demonstrated a good understanding of people's needs and how they liked to be supported.

Staff support, induction, training, skills and experience:
•Staff had received appropriate training and had the skills they required to meet people's needs. Staff told us they thought the training was effective and gave them enough information to carry out their duties safely.
•One staff member told us, "The training is really good, I have had moving and handling, dementia and nutrition." A second staff member described their initial induction as very good and informative, with plenty of opportunities to work alongside other staff before supporting people.
•The provider had training plans in place which were reviewed and updated on a regular basis. Records showed staff were able to undertake a range of training relevant to their role, including specialist training.
•Staff confirmed they received regular supervision from their line managers and were able to discuss any development or support needs they may have.

Supporting people to eat and drink enough to maintain a balanced diet:
•People were supported to eat and drink enough to maintain a balanced diet. We observed the lunchtime meal and saw people were provided with a three-course meal with a choice of options. People told us the cook tried to cater for individual tastes and preferences wherever possible.
•Staff were provided with guidance where people required specific diets and we saw staff followed this guidance during mealtimes.
•Staff provided assistance where people required support to eat and drink. This was given sensitively and people were supported to eat at their own pace.
•People and visitors were able to access a bistro bar in reception which provided a wide range of drinks and snacks available throughout the day.
•People's care plans included assessments to identify if they were at risk of poor nutrition. These included monitoring systems and referrals to health professionals for additional support.

Staff working with other agencies to provide consistent, effective, timely care:
•Staff worked with healthcare professionals, such as physiotherapists and dieticians, to ensure people received timely care and intervention when required.
•Staff also worked with GP's, palliative care teams and social workers when people required additional care,

for example, end of life.

Supporting people to live healthier lives, access healthcare services and support:
•People felt they had access to any healthcare services they needed. One person told us, "I haven't needed a doctor, staff would organise that for me. I have a regular chiropodist. I had an eye test fairly recently, the optician came in. A dentist came in and asked me about my teeth".
•People's care records provided an overview of the health care appointments people attended, and showed where external healthcare professionals had made any recommendations or actions for staff to follow.
•Staff communicated effectively with other staff in the service. There were systems in place to support the monitoring of people's needs and we observed staff followed this. For example, staff discussed pending hospital appointments and why these were required.

Ensuring consent to care and treatment in line with law and guidance:
•The 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
•We found the service was working within the principles of the MCA. Where conditions on authorisations to deprive a person of their liberty were in place, these had the appropriate legal authority and were being met.
•Staff had a good understanding of the MCA and we consistently heard them asking for consent to provide care and providing choices to people. One staff member told us, "I always ask if I can help first and support people to make choices such as their clothing."
•Staff understood that capacity may fluctuate and different approaches needed to be made dependant on people's mood or illness.
•People's care plans included the support they needed to make day-to-day decisions and choices and guidance where more complex decisions were required.

Adapting service, design, decoration to meet people's needs:
•The service had some dementia friendly signs to support people to locate different aspects of the home such as toilets and bathrooms to support them to remain independent and there were raised toilet seats and grab rails.
•Apartments had people's name or a meaningful symbol on the door to aid orientation, and people had been able to personalise their apartments with photographs and personal items.
•There was a range of quiet areas on the ground floor, where people could meet with visitors away from their apartment if they wished.

Good

Is the service caring?

Our findings

Caring - this means that the service involved people and treated them with compassion, kindness, dignity and respect

People were supported and treated with dignity and respect, and involved as partners in their care.

Ensuring people are well treated and supported; equality and diversity:
•People spoke positively about their relationships with staff. Comments included, "All staff are very caring, they give me enough time to do what I can," and "I genuinely believe staff are caring, they are very helpful. They know me well and do what I want without me having to tell them all the time."
•We saw that staff had taken time to get to know people and this supported them in maintaining positive relationships with people. For example, we heard conversations between staff and people discussing key interests, forthcoming events and family news.
•Staff spoke fondly and were respectful of people. One staff member told us, "The residents are so beautiful, that's why we come here; you have to know your residents well."
•Staff recognised and protected people's right to be treated equally and celebrated diversity. For example, where people communicated in a language that was not English, some staff members were able to converse in their preferred language and could share this communication with other staff. One staff member described how they had learnt specific phrases from a person's language which had improved communication and reduce their anxiety about the care they received. Staff had arranged a translation of a sacred book to enable a person to continue to follow their faith.
•Visitors were welcome at any time and people were supported to maintain relationships with friends and family.

Supporting people to express their views and be involved in making decisions about their care:
•People, with their relatives or representatives, felt involved in their care and this was reflected in care records we reviewed.
•Relatives told us they were involved in discussions and reviews about people's care. One relative told us, "Staff suggested I brought in photos of the family and they actually use this as a tool to communicate with [Name]."
•People had access to advocacy services if they needed them.
•Personal information was stored securely and only shared with the person's, or their representatives, consent.

Respecting and promoting people's privacy, dignity and independence:
•People were encouraged to be as independent as possible. A staff member told us, "I give people time when I am helping with their care to see what they can do for themselves."
•People's care plans included details on their preferred names, and how much they could do for themselves before they required assistance from staff. We observed staff followed this guidance when the addressed and supported people.
•Staff demonstrated a good understanding of how they protected people's dignity and right to privacy. This

included assisting people with personal care, and not discussing people's care openly in front of others.

Good

Is the service responsive?

Our findings

Responsive - this means that services met people's needs

People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:
•Care plans included people's life history, significant events, their wishes and preferences and routines that were important to them. This included the order people preferred their assistance to be provided and how staff should enter apartments and greet people.
•People and those important to them were involved and consulted throughout every stage of care planning.
•Care plans supported staff to provide personalised care. For example, one person had fluctuating abilities and staff were instructed to give them time to try and complete a task. The care plan advised staff to use doll therapy which had proved successful in comforting the person when they became anxious. We saw staff followed this guidance during our inspection visit.
•Care plans and records were kept under regular review to ensure the care provided continued to meet people's needs.
•People were supported to communicate and receive information in their preferred method.
•People had access to a range of meaningful activities and were able to choose if they wished to participate. These involved in-house sessions and visits within the local community or to areas of interest.
•Activities were provided by dedicated activity staff, with support from voluntary agencies. Activity staff regularly monitored and evaluated activities to ensure these were in line with people's interests and wishes.
•We observed activities provided which included baking and a reminiscence session, which people appeared to enjoy.
•Activities were advertised on communal notice boards under 'What's on this week' which enabled people and relatives to be aware of planned activities.
•People also had access to a library and board games when they wished.

Improving care quality in response to complaints or concerns:
•There were complaints procedures in place which detailed how people could raise concerns and complaints, and advised how these would be managed.
•The provider had received four complaints and these had been responded to in line with the complaints policy.
•People and relatives told us they knew how to raise concerns and complaints, though not all had confidence that these would be resolved to their satisfaction.
•The provider was in the process of investigating complaints at the time of our inspection and was open and transparent in ensuring these were investigated and resolved to improve the service people received.

End of life care and support:
•People were supported to discuss their end of life wishes as part of care planning.
•Staff worked proactively with other health and social care professionals to ensure people had a pain-free, dignified death.

•Staff had undertaken the training they needed to support people through end of life care.

Requires Improvement

Is the service well-led?

Our findings

Well-led - this means that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high quality, person centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:
•The service did not have a registered manager. A new manager had been appointed and was applying for registration with CQC at the time of our inspection visit.
•The manager demonstrated they understood quality performance and regulatory requirements
•People did not know who the manager was. Two relatives knew who the manager was, but others did not. One relative told us, "Having met the new manager, I am quite encouraged."
•At the time of our inspection, staff were unsettled and anxious about changes as a result of a change in provider. Staff were not always clear on their roles due to changes in systems of working, introduced by the new provider.
•The new manager was aware of the impact of changes and was working with the provider to address staff concerns.
•The provider undertook a range of audits and checks on all areas of the service. These included spot checks during the night and day and audits of records. Where improvements were identified as a result of checks and audits, these were recorded but records did not clearly show that actions had been taken and improvements made as a result. For example, areas requiring improvement following an audit of care records had been assigned to a senior for action. Quality assurance records did not demonstrate that appropriate action had been taken and the required improvements had been made.
•Senior managers visited the service on a regular basis to assess the quality of the service provision and progress with compliance. Visit reports were produced and statistical reports submitted for areas such as number of falls, deaths, safeguardings and personnel issues.
•The manager told us improvements were in progress to ensure people received a good quality service and stated their commitment to achieving this.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:
•The manager, together with representatives from the provider, held regular meetings for people and relatives to keep them informed of developments and to gain their feedback on all aspects of the service.
•People and relatives told us they were able to share their views, although they felt improvements were not always noticed as a result.
•Relatives felt overall there had been poor initial communication from the new provider during the change of provider and this had resulted in changes being made which had not always been clearly explained.
•The provider was in the process of sending out quality surveys to people and their relatives to gain their views and use these to drive improvements within the service.

•Staff had completed surveys which enabled them to share their views in confidence, and these were being collated by head office at the time of our inspection visit.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility:
•The provider and manager had a good understanding of their responsibility when things went wrong and had reported incidents appropriately to the Local Authority and CQC.
•The management and staff were passionate about the quality of service that people received and providing personalised care; care plans reflected this.
•The provider and manager were open about areas that needed to improve in the service and were working to develop approaches and systems that addressed concerns and improved the quality and consistency of the service.

Continuous learning and improving care:
•The manager displayed a commitment to improving care where possible. They acknowledged that the service was experiencing a time of change and this was unsettling for people, relatives and staff.
•The provider and manager were clear on how they wanted to develop the service.
•The manager had learnt from experiences in the service. They provided examples such as the challenge of managing expectations and striving for consistency in approaches from staff.
•They had used these experiences to ensure a clear recruitment framework was in place and in use to improve staff recruitment and retention.
•The provider supported managers and staff to access a range of resources to develop their knowledge and skills in line with best practice guidance.

Working in partnership with others:
•Referrals had been made appropriately for professional support including GP, occupations therapy and equipment services. We saw staff worked together with professionals to achieve good outcomes for people.
•Commissioners from the local authority had not specific concerns about the service.