Cleeve Lodge Care Limited

Cleeve Lodge Care Home

Inspection report

Cleeve Lodge Close
Downend
Bristol BS16 6AQ
Tel: 0117 970 2273
Website: www.kewcaregroup.co.uk

Date of inspection visit: 8 and 12 May 2015
Date of publication: 14/10/2015

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

Overall summary

This inspection took place on 8 and 12 May 2015 and was unannounced. The previous inspection of Cleeve Lodge Care Home was on 20 September 2013. There were no breaches of the legal requirements at that time. Cleeve Lodge Care Home is registered to provide accommodation and personal care for up to 33 older people (although the provider limited this to 30 by using shared rooms for single occupancy). At the time of the inspection there were 26 people in residence.

There was a registered manager in post. 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.

People were safe. All staff received safeguarding adults training and were knowledgeable about safeguarding issues. When concerns had been raised they had reported events to the local authority and CQC. Their recruitment policy ensured that unsuitable workers were not employed because pre-employment checks were robust.

A range of risk assessments were undertaken for each person and appropriate management plans were in place

Summary of findings

where needed. The premises were satisfactorily maintained and there were plans in place for refurbishment works. All maintenance checks were regularly undertaken.

The staffing numbers on duty were continually monitored to make sure they were appropriate and that each person's care and support needs could be met. Staff confirmed that the staffing numbers were appropriate.

Staff completed a programme of mandatory training to enable them to carry out their roles and responsibilities. New staff had an induction training programme and there was a programme of refresher training for staff. Care staff were encouraged to complete nationally recognised qualifications in health and social care.

People were supported to make their own choices and decisions where possible. Where people lacked the capacity to make decisions, assessments were recorded of best interest decisions. We found the home to be meeting the requirements of the Deprivation of Liberty Safeguards.

People were provided with sufficient food and drink. There were measures in place to reduce or eliminate the risk of malnutrition or dehydration. Arrangements were made for people to see their GP and other healthcare professionals as and when they needed to do so. People were administered their medicines as prescribed by their GP.

The staff team had good friendly relationships with the people they were looking after. People were able to participate in a range of different activities.

There was a staffing structure in place and junior staff were supported by senior staff and the registered manager. Daily team meetings and regular staff meetings ensured that all staff were kept up to date with any changes in people's needs and any events that had occurred or were due to take place.

Care records were kept for each person. These were well written and detailed, which ensured that people would receive the care and support they needed. Accurate records were kept of the care and support provided. People were involved in having a say how they were looked after and were encouraged to raise any concerns they may have.

There was a regular programme of audits in place to check on the quality and safety of the service. The responsibility of these checks were shared between the senior staff. The provider visited the service on a monthly basis and also checked on the quality and safety.

Summary of findings

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 safe.

People received care from staff who were trained in safeguarding and would recognise any abuse and take the appropriate action.

Staffing levels were appropriate and enabled them to keep people safe. Robust recruitment procedures ensured that only suitable staff were employed.

People's medicines were being managed safely.

Good

Is the service effective?
The service was effective.

Staff received training and support which helped them to do their jobs well.

People's rights were protected because staff were aware of their responsibilities in relation to the Mental Capacity Act 2005.

People enjoyed the meals and received the assistance they needed with eating and drinking. Staff supported people in ways which promoted their independence.

People were supported to obtain other services they needed in order to meet their health and care needs.

Good

Is the service caring?
The service was caring.

People were treated with respect and kindness. The staff team had good relationships with people and talked respectfully about the people they looked after.

Good

Is the service responsive?
The service was responsive.

People received the care and support that met their specific needs. Care planning documentation provided an account of what support was needed and how this was to be provided.

People were able to participate in a range of social activities. They were listened to and staff supported them if they had any concerns or were unhappy.

Good

Is the service well-led?
The service was well led.

There was a programme of checks and audits in place to ensure that the quality of the service was measured. Any accidents, incidents or complaints were analysed to see if there was any lessons to be learnt.

The home benefited from a registered manager who was approachable and provided good leadership. Staff felt supported in their job roles.

Good

Cleeve Lodge Care Home

Detailed findings

Background to this inspection

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

The inspection was unannounced and was undertaken by one adult social care inspector.

Prior to the inspection we reviewed the information we had about the service. This included looking at any notifications we had received from the service. A notification is information about important events which the provider is required to tell us about by law. We received 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.

During the inspection we received written feedback from six people living in the care home and five relatives. We spoke with the registered manager and five members of staff. We looked at three people's care documentation and other records relating to their care. We looked at staff employment records, training records, policies and procedures, audits, quality assurance reports and minutes of meetings.

Good

Is the service safe?

Our findings

We did not receive any direct comments from people living in the home or their relatives regarding their views of how safe they felt the service was. However we did receive many positive comments and an overall sense of satisfaction with the service provided.

Staff received safeguarding training as part of their mandatory training programme. Those we spoke with were aware of their responsibility to keep people safe. Staff were able to refer to the service's avoidance of abuse policy and procedure if they needed guidance. This set out the reporting protocols. Staff had completed a training session in keeping people safe and safeguarding adults. Staff knew about 'whistle blowing' to alert management to any poor practice they knew about. The registered manager had completed a safeguarding alerter course and management training with South Gloucestershire Council and said they had good links with the safeguarding team. The registered manager was able to talk about the procedures that had been followed when safeguarding concerns had been reported by a member of staff.

There were currently no staff vacancies as two new members of care staff had been recruited. The service had a recruitment policy in place and interviews with potential new members of staff were always undertaken by two or three interviewers. Disclosure and Barring Service (DBS) checks were undertaken with all staff before they started working in the service. A DBS check allows employers to check whether the applicant had any past convictions that may prevent them from working with vulnerable people. These measures ensured the provider had ensured all staff were suitable to work with vulnerable people.

Any risks to people's health and welfare was assessed. Assessments were completed in respect of the possibility of skin damage caused by pressure (also known as bed sores), the likelihood of falls, risks of malnutrition and moving and handling tasks. Where a person needed the care staff to support or assist them with moving or transferring from one place to another a moving and handling plan was devised. These set out the equipment required and the number of care staff to undertake any task. Other risk assessments and management plans were completed where appropriate. For example, in respects of the use of bed rails to maintain a person's safety, or the risk of choking. These measures were in place to ensure people were kept safe.

The service had a business continuity plan in place. This set out the arrangements in place in case the home needed to be evacuated, loss of utility services, or not enough staff were available A maintenance person was employed and there was a schedule of servicing by external providers of all equipment in place. There was a programme of checks to complete on a regular weekly or monthly basis in order to keep the premises safe. These included checks on the fire systems, hot and cold water temperature checks, the premises and security.

Staffing numbers per shift were kept under constant review and staff rotas were organised on a two weekly basis. At the time of our inspection there were four care staff on duty in the morning and afternoon until 6pm and then three until 10pm. Overnight there were two night staff. The staffing arrangements were confirmed by the staff the staff we spoke with and the duty rotas we looked at. In addition there were kitchen staff every day and activity staff three days per week.

One member of the senior staff was referred to as the 'Medication Champion' and took a lead role in ensuring the management of medicines was safe. People were administered their medicines by trained members of care staff at the prescribed times. Care staff we spoke with confirmed they had received training in the safe administration of medicines. The senior staff member said that if an error was made or the staff member did not complete the medicine administration record properly, extra supervision or training was arranged.

There were safe systems in place for the ordering, receipt, storage and disposal of all medicines. There were suitable arrangements in place for storing those medicines that need additional security. Records showed that stocks of these medicines were checked regularly and could all be accounted for.

Good

Is the service effective?

Our findings

People or their relatives said, “The way you look after mum is great and have a lot of time for her even when at their busiest”, “The staff always communicate with me and my sister if they have any concerns. They listen to our concerns as well”, “The care staff are first class” and “Everything is excellent”. One relative commented “It will be nice to get the new windows and boiler installed soon”.

All staff completed a mandatory programme of training that was relevant to their job role and ensured they could meet people’s needs. Newly appointed staff completed an induction training programme at the start of their employment. The service had access to the South Gloucestershire Council training programme. Staff members confirmed they received regular training and felt it helped them do their jobs better. Staff said they were well supported by both the registered manager and the provider who visited the service regularly. They said “We are listened to”.

All care staff were encouraged to undertake health and social care diploma qualifications (previously called a national vocational qualification NVQ)). Seventeen staff had already achieved at least a level two award and additional staff were doing their level two or three diplomas. The registered manager had completed their level five award in leadership and management and one of the senior care staff was working towards their level four award.

Staff received regular formal supervision and the role of supervisor had been delegated to one of the senior care staff. All staff we spoke with said the staff team worked well together and they worked for the benefit of the people who lived there. Extra supervision sessions were arranged with individual staff members where there needed to be discussions around work performance or an event that had happened. Staff supervision records were kept of all supervision meetings.

Comments that people/their relatives made in the recent questionnaires included, “X is still unhappy with the food which is regularly overcooked”. However other comments we received were, “The food is of a high standard and she is always happy with her meals”, “The food is excellent and a great variety. No one will ever be hungry in this home”, “The care staff are very good at assisting people to eat their meal” and “they feed her well”.

People were provided with sufficient food and drink that met their individual needs. There was a four week menu plan in place, (two week plan for those people who required a soft ‘mashed’ diet). There was a water machine and vending machine in the main lounge and people were provided with their own fridges and tea making facilities in their bedrooms (unless a risk identified). People were provided with a variety of main meals and finger foods and had the option of being served their meals in the dining room, lounge or their bedroom. The kitchen was open at all times and people could request additional snack foods and drinks at any time.

Body weights were monitored on a monthly basis and fortified meals were provided for those people who had lost weight. Specialist cutlery, plates and drinking vessels were provided to enable people to have their meals and drinks independently. Food and fluid monitoring charts were used where the staff needed to monitor how much people were eating and drinking.

People were encouraged to be independent and to make choices and decisions about their care where possible. The provider had policies and procedures on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). MCA legislation provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make decisions for themselves. DoLS is a framework to approve the deprivation of liberty for a person when they lack the capacity to consent to care or treatment.

People were assessed as part of the care planning process in relation to their mental capacity and ability to make decisions about their daily life and more important aspects that affect their life. Where people lacked the capacity to make decisions, assessments were recorded of best interest decisions. The provider/registered manager told us that best interest decisions were made with multiple staff, relatives and professionals as necessary. They told us that an independent mental capacity advocate (IMCA) had been arranged for two people in respect of ‘do not resuscitate’ decisions.

Good

Is the service effective?

The service was applying the principles of DoLS appropriately. The provider had submitted DoLS applications for three people but were still waiting for the authorisations to be made by the local authority.

People were supported to access the health and social care professionals they needed to meet their needs. Each person was registered with GP who visited the service on a weekly basis and saw those people who needed a doctor appointment. Staff would organise other health appointments as and when needed them. Examples of other professionals who visited the service included the district nurses, specialist nurses, chiropodists, dieticians and speech and language therapists (SALT), occupational therapists and physiotherapists.

Good

Is the service caring?

Our findings

People said staff were caring and friendly. Comments we received included, “The staff are very kind, respectful and caring”, “This is a brilliant care home and I would recommend it to anyone” and “I am very happy with the standard of care”. Comments that people/their relatives made in the recent questionnaires included, “Everyone is very friendly”, “The staff team seem very friendly and caring towards my mother. As long as she is happy about the way the staff treat her then the family is happy” and “X is very happy living at the home and we are happy too”.

Staff said, “We are a small home, one big happy family”, “We are keeping the business small so that it feels like a family” and “I would recommend the home for a family member”. Staff spoke respectfully and kindly about the people they were looking after. They said they liked to get to know people well and also their family members who visited. A keyworker system was in place in order to enable staff and the person to establish a trusting relationship. This staff member would then be able to advocate on their behalf if necessary.

Care plans evidenced that people were consulted on how they wanted to be looked after. Relatives were also involved where the person was not able to participate. People were asked by what name they preferred to be called and what things were important to them. This information was incorporated into their care plans.

Staff were taught to respect people’s dignity. The bedroom doors and the doors into bathrooms and toilets were closed when people received care or were assisted to use the toilet. Staff knocked on people’s doors and either waited to be invited in, or if the person was not able to answer, paused for a few moments before entering.

People were cared for until the end of their life where this was possible and the relevant support was provided by medical and nursing services. A member of staff who had completed end of life care training with the local hospice was the end of life champion for the staff team. They had put together a booklet and given this to family members after their relatives had passed away. This provided guidance and led them through what they had to do to deal with immediate practical matters. The booklet also provided contact details about other agencies where they could get bereavement advice.

Good

Is the service responsive?

Our findings

People or their relatives said, “My relative has dementia and we are very grateful for the kind understanding way she is being treated, especially when she is a bit confused”, “We have been very happy with mums personalised care. The manager and staff have gone out of their way to individualise mum’s care to her special needs”, “I have been at the home for over four years and I am well looked after. I am lucky”.

Comments that people/their relatives made in the recent questionnaires included, “Sometimes staff are very busy and promise to do something and then forget” and “I get the help I need”.

People’s care needs were assessed before admission to the home and a care plan was written, based upon the assessment details. This ensured the service was able to meet the person’s specific care needs and any specific equipment was available, for example moving and assisting and sensor equipment. People were offered a visit to the home prior to their admission to ensure the service was acceptable to them. A personalised care plan was written. These detailed specific routines, preferences and wishes to ensure the person was provided with a consistent service that met their needs. It was evident that people were involved in preparing their care plans and those records we looked at provided an accurate and detailed account of the care and support provided.

Care plans were checked on a monthly basis, but fully reviewed on a yearly basis. The person’s needs were reassessed and the care plan was either updated or rewritten. People were involved in this process and encouraged to have a say about their care and support and how they wanted to be looked after. This measure ensured that the care plans remained a true reflection of the person’s care needs and the staff team were provided with guidance and instructions on what care to provide.

Staff received a verbal handover report each day they worked. A handover is where important information is shared between the staff during shift changeovers. Staff were made aware of any changes to people’s care needs and this ensured a consistent approach.

There was a weekly programme of activities for people to participate in and a copy of the programme was displayed in the reception area. The service employed one activity co-ordinator for 20 hours per week. These hours were flexible and could be used at the weekends. There was a monthly church service followed by tea and cake. The activity co-ordinator kept an activities record for each person. These contained a social history of the person and also a log of all the activities the person had been involved in, photographs and any art work. The files were passed to family members when the person passed away as a memento of their time at Cleeve Lodge.

The complaints policy was kept under review and updated as and when necessary. People were provided with a copy of the complaints procedure and a copy was displayed in the main reception area. People said, “The staff are always ready to listen to what I have to say and change things” and “I have no concerns but would speak up if I did”. The registered manager and staff said they encouraged people to express any concerns or anxieties they had and then dealt with these promptly. The service had not received any formal complaints in the last 12 months however had dealt with two concerns. One was in respect of an item of clothing going missing and the other was because a person had been missed on the tea round. Appropriate action was taken by the registered manager in both cases. The Care Quality Commission have not received any complaints or concerning information regarding this service.

Good

Is the service well-led?

Our findings

We did not receive any direct comments from people living in the home or their relatives regarding their views of how the home was run. However we did receive many positive comments and an overall sense of satisfaction with the service provided.

Quality assurance questionnaires were undertaken on several occasions throughout the year and the results were analysed. People were asked to rate life at the home, the home, the staff team, activities and communication. We looked at the results of the latest questionnaires and it was recorded that 18 of the forms had been completed by relatives and three by visiting professionals. It was unclear whether any forms had been completed by people who lived in the home. The majority of responses rated the service as very good or good, but there were a few fair or poor responses. The poor responses were in respect of the external appearance and internal decoration of the home and the efficiency of the intercom access. Additional comments were recorded in the report, which were on the whole positive. There was no action plan in place to address the negative comments in the responses (apart from a comment that the intercom system had been checked). However the provider told us in their PIR prior to the inspection that they were waiting for planning permission to be granted for the replacement of windows and there was a plan to refurbish bedrooms.

Staff meetings were held regularly and daily team meetings were held to help care staff communicate changes or concerns regarding people's care. We looked at the minutes of a meeting that had been held with the kitchen staff where concerns had been raised about the provision of a soft diet for one person and other menu related issues. The results of this meeting had not resulted in an improvement plan and it was unclear what actions had been taken.

The staff team were led by the registered manager. They had a level five qualification in leadership and management. A relative commented in the recent questionnaire that "Care has been transformed by the current manager". Team leaders had level three qualifications in a health and social care and one was working towards their level four.

Staff said the registered manager was approachable and would be part of the staff rota to cover staff sickness or staff shortages. This meant the registered manager had a good understanding of the day to day running of the home. There was an on-call system in place to cover evenings and weekends. Protocols were in place on calling an ambulance if a person had fallen and was injured. The guidance provided helped the care staff determine whether there was a need to call an ambulance. The on-call was shared between the registered manager, senior care staff and the shift leaders.

There were systems in place in order to monitor the quality of the service. Audits were completed by senior management on a rotational basis. Audits were undertaken of care plans, weekly medication and controlled drugs checks, finances, the environment and any accidents. The provider was supplied with a monthly operations manager visit report and these covered staff and 'resident' issues. Action reports were recorded and followed up in the next report.

Any accidents and incidents were clearly logged on accident/incident forms. The forms recorded details of the event, action taken including medical intervention, documentation updates made and who was notified of the event (i.e. family). The form also included observations made one, two, four, six and 12 hours after the event. These measures ensure that any event is always followed up to ensure appropriate action had been taken. The registered manager and provider analysed all events on a monthly basis to identify emerging trends, in order to prevent or reduce reoccurrences.

The registered manager was aware when notifications of events had to be submitted to CQC. A notification is information about important events that have happened in the home and which the service is required by law to tell us about.

A copy of the complaints procedure was displayed in the reception area but was also given to people and their relatives on admission. The policies and procedures we looked at had been regularly reviewed. Senior staff we spoke to knew how to access these policies and procedures.

The provider had an improvement plan in place for the service. This included the provision of additional training for the staff team to enhance people's experience, to

Good

Is the service well-led?

improve activities to include outings, to reintroduce the offer of relative meetings and to provide a photo-book of menu's to provide a visual aid for people when making menu choices.