Bondcare (London) Limited

Coniston Lodge Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service effective?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Coniston Lodge Nursing Home is a nursing home which can provide personal and nursing care to 92 adults. At the time of our inspection 34 people were living at the service. The majority of people were older adults. Some were living with the experience of dementia and some were being cared for at the end of their lives. The service was managed by Bondcare (London) Limited, a private organisation.

People's experience of using this service and what we found
There were appropriate procedures for infection prevention and control. However, staff did not always wear face masks correctly and this meant there was an increased risk of infection being spread.

There had been improvements in the way medicines were managed since the concerns raised earlier in 2020. However, staff did not always follow prescribers' instructions when administering nutritional supplements. Protocols describing when PRN (as required) medicines should be administered were not personalised. This meant there was a risk people would not receive medicines when they needed them.

There had been improvements to quality monitoring and responding to accidents, incidents and safeguarding alerts since the time when we were first alerted to concerns. However, there was a lack of proactive measures to identify root causes and plan to prevent these from reoccurring.

The provider had recruited a new manager and feedback from stakeholders indicated the service had made improvements. The relatives of people using the service told us they felt people were safe. Staff felt supported and told us they had the information they needed to carry out their roles.

Following the inspection, we provided feedback to the manager and regional support manager. They assured us they would address the areas of concern regarding the use of PPE (personal protective equipment) and medicines management.

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

Rating at last inspection
The last rating for this service was requires improvement (Published 8 January 2020). We identified breaches in relation to person centred care, dignity and respect, safe care and treatment and good governance. Following this, we imposed conditions on the provider's registration. These conditions require the provider to update us each month about the service, including any identified concerns and how they are addressing these. The provider completed an action plan after the last inspection to show what they would do and by when to improve. They have updated us each month to tell us the progress they have been making.

This service has been in Special Measures since 26 April 2019.

Why we inspected
We undertook this targeted inspection to follow up on specific concerns which we had received about the service and areas of high risk identified following our previous inspection. The inspection was prompted in part, in response to concerns received about safeguarding and medicines management. A decision was made for us to inspect and examine those risks.

CQC have introduced targeted inspections to follow up on Warning Notices or to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question. We found no evidence during this inspection that people were at risk of harm from these concerns.

Please see the safe, effective and well-led sections of this full report. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Coniston Lodge Nursing Home on our website at www.cqc.org.uk.

Enforcement
At this inspection, we have not looked at all the Regulations which were breached at the previous inspection. Therefore, we were unable to make a judgement about whether these had been fully met.

We have identified some improvements. However, we also found some care and treatment was not always safe. For example, staff did not always correctly wear PPE (Personal protection Equipment) and medicines procedures were not always followed in a safe way.

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service through the conditions we imposed following the last inspection. We have not taken addition action.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures:
We have not changed the rating at this inspection and the service remains in special measures.
This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within six months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions their registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question where we had specific concerns.

We will assess all of the key question at the next comprehensive inspection of the service.

Is the service effective?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question where we had specific concerns.

We will assess all of the key question at the next comprehensive inspection of the service.

Is the service well-led?

Inspected but not rated

At our last inspection we rated this key question inadequate. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question where we had specific concerns.

We will assess all of the key question at the next comprehensive inspection of the service.

Coniston Lodge Nursing 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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted as part of our Thematic Review of infection control and prevention in care homes.

Inspection team
The inspection team included an inspector, an assistant inspector, a nurse specialist advisor and a member of the CQC medicines team.

Service and service type
Coniston Lodge Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

There was a manager. They were in the process of applying to be registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the provider 24 hours' notice of the inspection. This was because we needed to make sure we could carry out our inspection safely, given the current situation with the pandemic.

What we did before the inspection
We contacted the local authority and clinical commissioning group for feedback about their experiences of the service. We looked at all the information we held about the provider, which included safeguarding alerts, notifications of significant events and information which had been shared with us by stakeholders.

We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We also reviewed the action plans and updates the provider had sent us each month. These are required because we have imposed conditions on the provider's registration requesting these.

We used all of this information to plan our inspection.

During the inspection
We spoke with staff working at the service, including the manager, regional support manager, clinical lead, regional clinical lead, two other nurses, a senior care worker and four care workers. We looked at the care records for eight people who use the service. We also looked at records of safeguarding alerts, complaints, accidents and incidents along with meeting minutes and other quality assurance records used by the provider.

We conducted a partial tour of the building and looked at records relating to infection prevention and control.

We looked at how medicines were being managed.

After the inspection
We spoke with relatives of eight people who used the service and members of the local authority safeguarding team. We asked for feedback from some healthcare professionals who worked with people living at the service, although we did not receive a response.

Inspected but not rated

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. We have not changed the rating of this key question, as we have only looked at the part of the key question, we had specific concerns about.

We will assess all of the key question at the next comprehensive inspection of the service.

Using medicines safely
At the last inspection of 1 October 2019, we identified medicines were not always managed in a safe way. This was a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We observed staff giving prescribed medicines and nutritional feeds to people. Staff were polite, gained permission and gave medicines. They signed for each medicine on the medicines administration record after giving it. However, nutritional feeds prescribed to some people were not mixed and made up as per the manufacturer's instructions.
● Some people were prescribed medicines to be given when required. However, protocols were not in place to give these medicines consistently as prescribed.
● Medicine care plans were not in place for some people. Where these were in place, they did not have accurate and adequate information related to medicines. This meant there was a risk staff may not be able to support people's medical and health needs effectively.
● There was a lack of information in people's care plans to help staff monitor or manage side effects of high-risk medicines such as insulin (a medicine used to control blood sugar levels). This meant there was a risk, they may not be able to respond appropriately and take necessary action to monitor and manage side effects.

Failure to safely manage medicines put people at risk. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was a medicine policy to support medicines management. However, staff did not always follow it.
● Staff were competency assessed and received training to handle medicines.
● Medicines were stored securely and at appropriate temperature.
● Some people were given medicines covertly. The staff had carried out best interest decisions involving the GP. The pharmacist was consulted to seek advice how to safely give people their medicines covertly. Covert medicines are given in a disguised format, for example in food or in a drink, without the knowledge or consent of the person receiving them.

Assessing risk, safety monitoring and management
At the last inspection of 1 October 2019, we identified risks had not been clearly assessed and there was not enough information about how these should be mitigated. This was a breach of Regulation 12 (safe care and

treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As this inspection was a targeted inspection, we focussed specifically on identified risks, and were not able to make a judgement about whether this part of Regulation 12 had been met. We will assess this at the next comprehensive inspection of the service.

● The local authority had alerted us to concerns about the number of falls and accidents which had happened at the service. During the inspection, we identified a small number of people regularly experienced falls and other incidents. We found their care plans had been updated with this information.
● Where people were at risk of falling the staff had created risk assessments relating to this. These were regularly reviewed and updated. There were other risk assessments relating to specific health conditions. These were clearly written, and staff had access to the information, so they knew how to reduce these risks.
● The staff had also created specific risk assessments relating to Covid 19 and whether people were at increased risk due to their health needs, physical condition or ethnic background. The staff were aware of these assessments.
● People's equipment needs had been assessed. The equipment people needed to keep them safe, such as safety mats and bedrails, was in place. These were regularly checked by staff to make sure they were in good working order and continued to be appropriate. Staff recorded how they supported people to minimise risks. For example, by repositioning people who were at risk of developing pressure sores. However, we identified gaps in the records for one person. These indicated the person had not been repositioned as often as they needed. We discussed these with the clinical lead who agreed to investigate this.

Preventing and controlling infection
● Staff had been provided with PPE (personal, protective equipment) to help keep themselves and others safe. However, we identified the staff were not always wearing this correctly. Some staff were not wearing face masks when they were sitting close to others (not social distancing). Many of the staff wore masks incorrectly, because they did not cover their noses. This increased the risk of the spread of infections. We also saw staff removing masks to speak with others or to wipe their faces and then replacing the same mask. This practice is not consistent with the guidance for wearing face masks and could result in contamination and spread of infection.

Failure to follow guidance for wearing PPE increased the risk of transmitting airborne infections. This was a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks would be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Systems and processes to safeguard people from the risk of abuse
● The inspection was triggered in part by the high number of safeguarding allegations. We looked at how the provider had responded to these and found they had worked with the local authority to investigate

these and implement plans to protect people.

● The staff told us they had received relevant training relating to recognising and reporting abuse. We saw this was also discussed in staff supervisions and meetings to make sure they were aware of their responsibilities in relation to this.

● New systems which had been introduced were designed to help safeguard people. These included closer monitoring of people's care, clinical needs and wellbeing by senior staff as well as better recording systems.

Inspected but not rated

Is the service effective?

Our findings

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

At the last inspection this key question was rated as requires improvement. We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about. We will assess all of the key question at the next comprehensive inspection of the service.

Supporting people to live healthier lives, access healthcare services and support
At the inspection of 1 October 2019, we found people had not always received personalised care relating to their health needs. This was a breach of Regulation 9 (person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As this inspection was a targeted inspection, we focussed specifically on identified risks, and were not able to make a judgement about whether Regulation 9 had been met. We will assess this at the next comprehensive inspection of the service.

- The inspection was in part triggered by concerns about people's access to healthcare services and communication with healthcare teams. We found this had improved and the staff had regular contact with people's GPs and other healthcare professionals. Appointments had been arranged via video calls, where possible, to reduce the number of visitors at the service.
- The staff had created care plans relating to people's different healthcare needs. These were appropriately detailed and included information about their health conditions and the support they needed with these. There were records to show people's healthcare conditions were monitored and the staff responded if and when they became unwell.

Inspected but not rated

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as inadequate. We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about. We will assess all of the key question at the next comprehensive inspection of the service.

Continuous learning and improving care
At the inspection of 1 October 2019, we identified the systems for assessing, monitoring and mitigating risks and assessing, monitoring and improving the quality of the service were not always operated effectively. This was a breach of Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As this inspection was a targeted inspection, we focussed specifically on identified risks, and were not able to make a judgement about whether Regulation 17 had been met. We will assess this at the next comprehensive inspection of the service.

● Since the last inspection, there had been a high number of safeguarding allegations, accidents and concerns around medicines management. The local authority representatives told us it was difficult for them to make a judgement about improvements at this time. One professional commented, ''[Whilst the number of safeguarding referrals has reduced] it is important to highlight that the majority of previous referrals were raised by external agencies and families [who have not been visiting the home for several months during the lock down].''
● The provider was working closely with external agencies to monitor and respond to safeguarding allegations and other identified concerns.
● We saw there were systems designed to respond to risks. For example, following accidents and incidents, the staff sought medical assessment (when needed) and monitored people's wellbeing. Care plans were also updated following these incidents. However, there was a lack of proactive measures to identify root causes and plan to prevent these incidents from reoccurring. This was also reflected in the feedback from one social worker who told us they had asked the staff on ''multiple occasions'' to investigate the cause of pain which resulted in one person's agitation. They explained this had not happened.
● We also identified there was limited evidence of reflective practice following incidents where staff could discuss these and learn from them. Some staff commented they did not feel they had enough support with their emotional wellbeing. There had been incidents which had resulted in injuries to staff. Records of these did not include evidence of discussion with staff or reflection about what had happened.
● Feedback from relatives of people who lived at the service and staff was generally positive about the improvements. They told us they thought the new manager was supportive and had introduced some important changes. Comments from relatives included, ''[The manager] has changed the style at the service and the staff have been amazing'' and ''I think things are improving now.'' Comments from staff included, ''[The manager] is very kind and approachable'', ''It has not been easy during the Covid 19 pandemic but

[the manager] has been a good leader'' and ''When I started working here [earlier in 2020] it was dangerous, but things have really improved.''

● Some systems for managing the service had improved. These included daily audits by the manager and daily meetings with the staff to discuss any concerns at the service. Care plans had been updated and information was more personalised, accurate and up to date. There had also been improvements in staffing levels with more permanent staff employed.