Tamaris (South East) Limited

Lydfords Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected Lydfords Care Home on the 30 October 2017 and the inspection was a focused inspection. Lydfords Care Home provides accommodation and nursing care for up to 43 people who have nursing needs, including poor mobility or diabetes, as well as those living with dementia. On the day of our inspection, there were 41 people living at the service. The home is a large property, spread over three floors, with a communal lounge, dining room and large gardens. It is situated in East Hoathly, East Sussex. Lydfords Care Home belongs to the large corporate organisation called Four Seasons. Four Seasons provide nursing care services across England and have several nursing homes within the local area.

The service had a registered manager in place. 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.

At the last comprehensive inspection on the 15 and 16 September 2016, the service was rated as 'Good' overall and Requires Improvement in the 'effective' domain. This focused inspection was prompted in part, by a notification of a serious injury involving a person who lived at the service. The incident is subject to an investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident, indicated potential concerns about the management of risk in relation to fire safety and falls. This inspection examined those risks. We therefore looked at two key questions, is the service safe and well-led? This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Lydfords Care Home on our website at www.cqc.org.uk

At this inspection the management of medicines was not consistently safe. Guidelines were not always in place for the use of 'as required' medicines. Documentation failed to reliably record the reason for administration for the use of 'as required' medicines. This meant the provider was unable to monitor whether the medicine was being administered for its intended usage. People received their medicines on time, however, the provider had not ensured that medicines were stored or managed safely at all times. Staff left the medicine trolley unattended during inspection. We have identified this as an area of practice that needs improvement.

Staffing levels were based on an assessment of people's individual care needs. People and staff felt staffing levels were sufficient. However, observations throughout the inspection noted that the call bell system was constantly ringing. People raised concerns that they felt they had to wait for assistance. An audit of the call bell system found it failed to consistently record when people's call bells were answered and when a number of people had pressed their call bells, the system did not record who pressed their call bell first. Steps were in the process of being taken to replace the call bell system. However, we have identified this as an area of practice that needs improvement.

Steps had been taken to ensure the building complied with fire regulation standards. A fire risk assessment dated May 2017 identified a number of shortfalls. Appropriate action had been taken to address the shortfalls. Training had been provided for staff to become fire wardens and fire drills were now taking place.

People were protected from harm and abuse. There were appropriate, skilled and experienced, permanent staff who had undertaken the necessary training to enable them to recognise concerns and respond appropriately. Risk assessments ensured that risks were managed and people were able to maintain their independence.

Staff were checked before they started working with people to ensure they were of good character and had the necessary skills and experience to support people effectively.

People, relatives and staff spoke highly of the registered manager. One staff member told us, "The manager is a fantastic boss and a fantastic nurse. We've got a staff meeting this week." Quality assurance systems were in place to drive improvement and check the safety and quality of care delivered.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Lydfords was not consistently safe.

The management of medicines was not consistently safe. Systems were in place to determine staffing levels, however, the call bell system was not consistently fit for purpose.

Staff had a good understanding about how to recognise and report safeguarding concerns. Appropriate checks where undertaken to ensure suitable staff were employed to work at the service.

People told us they felt safe living at Lydfords Care Home and staff were aware of the measures to keep people safe.

Is the service well-led?

Good

Lydfords Care Home was well-led.

The registered manager promoted an open and positive culture which focussed on people.

Quality assurance processes monitored practice to ensure the delivery of high quality care and to drive improvement. The management team were committed to the continually improving the service.

People and staff were very positive about the leadership and management of the service.

Lydfords 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.

We undertook an unannounced focused inspection of Lydfords Care Home on 30 October 2017. This inspection was carried out following a safety incident at the service. The team inspected the service against two of the five questions we ask about services: is the service safe and is the service well-led? The inspection was carried out by two inspectors.

The provider had not completed a Provider Information Return (PIR), because we had not requested one before this focused inspection. This is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. Before the inspection we reviewed all the information we held about the service; we looked at previous inspection reports and any notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law.

We spoke with the registered manager, deputy manager, three registered nurses, four care staff, the activity coordinator, seven people who live at Lydfords Care Home and one visiting relative. We also contacted four relatives via telephone after the inspection to gain their feedback. Their comments have been included within the body of the report.

We looked at five care plans and the associated risk assessments and guidance. We looked at a range of other records including medicines records and audits, maintenance records, three staff recruitment files and staff rotas. We observed people receiving their lunchtime medicines.

We last inspected this service on 15 and 16 September 2016, when the service was rated as 'Good' overall.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Lydfords Care Home. One person told us, "I feel very safe living here because at night time if I need anyone, staff are around to help me." Another person told us, "I don't like feeling poorly, but there's always someone to give me a hug and cuddle me." Relatives also confirmed they felt confident leaving their loved ones in the care of Lydfords Care Home. However, despite these positive comments, we found areas of care which were not consistently safe.

The management of medicines was not consistently safe. Guidance produced by the National Institute for Health and Care Excellence (NICE) advises of the importance of the six 'rights' of administering medicines. These rights include right person, right medicine, right time, right route and right dose. We observed the administration of medicines and found that the staff member clearly explained the purpose of the medicine and provided the individual with a drink of their choice. However, when supporting people to take their medicines, the medicine trolley was left in the corridor open and unattended by staff on a two occasions whilst they supported people to take their medicines in their rooms. Guidelines were in place for the administration of 'as required' medicines (PRN) outlining the reasons a person needed their medicine and how often it was to be given in 24 hours, however, these guidelines were not consistently robust. For example, where people were prescribed antipsychotic medicines, PRN protocols advised on the reason why the medicine was administered, but information failed to provide guidance on the steps for staff to take before administering the medicine. One person was prescribed an antipsychotic medicine which was being administered; however, documentation did not reflect the reason why. Staff members were able to advise that the reason for administration was due to agitation and the registered manager told us, "We've identified certain situations which are triggers for the person and we've found that offering them a cup of tea, change of scenery and time to themselves usually helps but if not, we will consider the PRN medicine." Staff were clear on the purpose of PRN medicines, despite this not consistently being reflected within documentation. However, failure to consistently record the purpose of why antipsychotic PRN medicines were being administered meant the provider was unable to monitor that the medicine was being administered for its intended usage and whether the medicine was achieving its expected outcome. We have identified this as an area of practice that needs improvement.

We recommend that the provider seeks guidance from a national source about safe administration of medicines.

Staff were knowledgeable about the medicines they gave. The Medication Administration Record (MAR) folder contained a list of staff names and signatures at the front to show who was responsible for giving the medicines out. At the front of each person's MAR was a photograph for identification purposes, their name, date of birth and allergies. The medicines fridge and medicine room temperatures were monitored daily to ensure they remained within safe levels. Medicines were ordered appropriately and medicines which were out of date or no longer needed were disposed of following safe procedures. People had personalised medicine care plans in place which considered the support they required to safely receive their medicines.

Registered nurses had access to pain management tools which demonstrated that steps were taken to

mitigate the risk of people experiencing any pain or being in discomfort. For example, pain assessment charts were completed which considered the person's own description of pain, what makes the pain better and what makes the pain worse.

Systems were in place to determine staffing levels based on people's individual care needs. Each person had an individual care needs assessment. This was inputted on the provider's electronic care system, which would then determine the number of staff required on each shift. The registered manager told us, "According to our dependency assessment, we require seven care staff in the morning but we actually provide eight on the floor. We are providing staffing levels above the assessed need but I would rather provide additional staff." Staff felt staffing levels were sufficient and our own observations demonstrated that people's care needs were met in a timely manner. One staff member told us, "Everyone has pulled together; we've got a fantastic team. Staffing works out well with two per corridor. We fit with people's preferences about when they like to get up and go to bed. Some people like to get up really early so the night staff assist them." However, throughout the inspection, we observed that the call bell system was ringing constantly. People also commented that they felt they had to wait a long time for staff to respond to their call bells. One person told us, "My only annoyance is that staff can take a long time to answer my call bell. They are very busy and they are lovely but at times it does take a long time." A relative told us, "Mum does tell me that she has to wait and I do hear the call bell system ringing when I visit."

A call bell system was in place which recorded the time an individual pressed their call bell and the time when staff responded. However, this system was not always fit for purpose and failed to consistently record when call bells were responded to. For example, we conducted an audit of call bell response times and found that call bells were usually answered prompted. However, on a number of occasions, we could not identify when a person's call bell had been answered. For example, on the 20 October 2017 one person pressed their call bell at 16.37pm. Documentation did not reflect when it was answered. We brought this to the attention of the registered manager who was unable to identify when it was answered. They told us, "Sometimes the call bell print out states controller and we believe that's when a call bell was answered but we have identified that the call bell system needs looking at and we have escalated this to our head office. The call bell system also doesn't reflect who rang their call bell first when a number of people are ringing at the same time. This means that staff do not know who pressed their call bell first and may respond to someone else when another person pressed their bell first." Concerns regarding the call bell system had been raised to management via 'resident' feedback and the registered manager was actively addressing the concerns. Subsequent to the inspection, the registered manager confirmed that a quote had been sourced to replace the call bell system. However, people's experience was not consistently positive and we have therefore identified this as an area of practice that needs to improve.

Staff recruitment records demonstrated that appropriate checks were undertaken before staff began work. This ensured as far as possible only suitable people worked at the service. Checks included the completion of application forms, a record of interviews, confirmation of identity, references and a disclosure and barring check (DBS). These checks identified if prospective staff had a criminal record or were barred from working with children or adults at risk. There were systems in place to ensure staff working as registered nurses had a current registration with the Nursing and Midwifery Council (NMC) which confirmed their right to practice as a registered nurse.

Safeguarding incidents had been referred to the appropriate external bodies for investigation and the provider had notified the Commission of these events; which is their statutory duty. Staff understood their responsibilities in relation to identifying and reporting any concerns they may have about people. Staff were able to tell us what may constitute abuse and training records confirmed staff had received essential safeguarding adults training. Where safeguarding concerns had been raised, the management team worked

in partnership with the local safeguarding team to ensure the safety of their 'residents'. Support was also provided to staff in the forum of de-brief sessions and following significant safeguarding concerns, learning had been taken forward and shared with the staff team. One staff member told us, "We had formal feedback about one safeguarding incident and learning from that."

Effective systems were in place to ensure potential risks to people's safety and wellbeing had been considered and assessed. Steps were taken to mitigate and reduce the risks wherever possible in a way that took full account of people's individual needs and personal circumstances. This included areas such as mobility, nutrition, medicines and skin care. The registered manager adopted a positive approach to risk management which meant that safe care and support was provided in a way that promoted people's independence wherever possible. Where people required the assistance of two staff members to move and transfer along with a mobility aid (hoist), risk assessments considered the equipment required, handling constraints and other factors which may prevent a safe transfer. One person told us, "I've recently required a hoist to help me get into bed and I feel ever so safe in it. Staff are very good and always explain what is happening."

Risks associated with pressure damage was managed safely. Management of pressure damage is an integral element of providing safe care to people living in nursing homes. Pressure damage is often preventable and requires on-going monitoring and nursing care input. We looked at the management of pressure damage throughout the home. Risk assessments were in place which calculated people's risk of skin break down (Waterlow score). Where people were assessed at high risk, actions were implemented to reduce these risks. These included the implementation of air flow mattresses and regular re-positioning. Input had been sought from the Tissue Viability Nurse where the person's skin integrity had broken down and nursing staff followed specialised wound care management plans. Documentation reflected that people's dressings were changed in line with the frequency recorded in their wound care management plan. Risks associated with wound care were reviewed weekly and the management team completed a weekly clinical audit of all wounds within the service. This enabled the management team to have strategic oversight of any risks related to wounds deteriorating.

Risks associated with fire safety had been addressed and steps taken to ensure people lived in an environment that was safe and met their needs. A fire risk assessment undertaken by the local fire service in May 2017 identified a number of significant shortfalls. An action plan had been created following the risk assessment in May 2017 and the registered manager demonstrated that all shortfalls identified had been acted upon and improvements made. For example, the fire risk assessment identified that compartmentation within the building was not adequate and that the ceiling was not fire retardant. All ceilings within the service had been replaced with fire retardant ceiling compartments. This meant in the event of a fire, the ceiling would provide additional protection against the fire. Actions also included for the provider to undertake regular fire drills and for a fire warden to be present at every shift. Documentation confirmed that fire drills were now taking place and training documentation confirmed nine staff members had received fire warden training.

People's individual ability to evacuate the building had been assessed and people had personal evacuation plans which considered the support people required to evacuate the building in the event of a fire. Fire evacuation mats were in place in the event of a vertical evacuation which staff had received training on. One staff member told us, "We have fire drills every six months, but they arrange extra for new staff. Fire awareness training is part of induction and it includes use of the rescue chairs and mats, and how to use the fire panel and do all the checks if the alarm goes off. I'm a fire warden, I'm confident in staff knowledge. We did a practice evacuation with 13 residents in 8 minutes, using all the equipment we would have to use."

Good

Is the service well-led?

Our findings

There was a positive culture at the home that was supported by a registered manager who took steps to ensure this was inclusive and empowering for people who lived there. People, relatives and staff spoke highly of the registered manager. One person told us, "The manager is friendly but firm, we have a laugh together." Another person told us, "In many care homes, it is not often that the boss lady fills up your water jug. She's a good manager." One staff member told us, "The manager is very much a part of the home. She spends time around the home and knows everything; she is available on-call too." Relatives confirmed that they would recommend the home and one relative told us, "The staff are incredibly caring and work really hard, communication is excellent."

The registered manager was open and transparent. They consistently notified the Care Quality Commission of any significant events that affected people or the service. Before the inspection, we contacted the registered manager due to a safety incident at the service. They were responsive to our concerns and informed us of the action they had taken in response to our concerns raised. The registered manager remained fully aware of updates in legislation that affected the service. The service's policies and operating procedures were appropriate for the type of service and clearly summarised, to help staff when they needed to refer to them. They were reviewed on an on-going basis, were up to date with legislation and fully accessible to staff for guidance. The service operated a policy of the month which was displayed in the staff room and staff were required to sign a signature list to evidence that they had read the policy. The policy of the month on the day of the inspection was 'nutrition.' Records were kept securely and confidentially. They were archived and disposed as per legal requirements.

The service had a strong, visible person centred culture which was good at helping people to express their views so they understood things from their points of view. The provider had introduced an initiative called the 'Quality of Life Programme.' The 'Quality of Life Programme' enables feedback to be obtained from people and their relatives through the use of technology. The service had been provided with several iPads which provided staff with the ability to obtain feedback from people on a daily basis and make it easier for people to provide feedback. Feedback was then reviewed to help improve service delivery and improve people's quality of life. Where feedback had been received, the registered manager was able to demonstrate what action had been taken. For example, one person fedback concerns over staff's lack of competence with hearing aids. In response to the feedback, the registered manager arranged for bespoke training for staff on hearing aids and hearing aid batteries. 'Resident' meetings also provided a forum for people and their relative's voices to be heard. Minutes from the recent resident and relative meeting in September 2017 reflected that staffing levels, CQC and activities were discussed. People were at the forefront of the running of the service and the Registered Manager expressed dedication in the importance of inclusion for people's points of view to be heard.

The provider and registered manager gained oversight of the quality and safety of the service through a number of different means. The regional director visited the service on a monthly basis and reviewed care plans, staffing levels, recruitment and various other elements of care. Care plans were subject to a formal audit and health and safety checks also took place. Any shortfalls or actions were added to the service's

action plan which the registered manager updated weekly. For example, the recent audit completed by the regional director found that 'my choices' booklets had not been consistently completed. This shortfall was added to the action plan and the registered manager demonstrated that action had been taken to address the shortfall.

Each person had a range of documentation in place which included repositioning charts, food and fluid charts, urine output logs and topical medicine administration records. During the inspection, we identified some shortfalls with documentation. For example, staff were not consistently recording people's urine output when they had a catheter in-situ. Topical medicine administration records contained unexplained gaps alongside people's repositioning charts. These shortfalls had been identified internally by the registered manager as part of their quality assurance checks. They told us, "We have identified these concerns and the action we have taken includes discussing the concerns in staff meetings and also sending out letters to staff." The registered manager was able to demonstrate that people received the care that they required and omissions with documentation did not indicate that people had not received the care they required. The provider's internal quality assurance framework enabled the registered manager to identify these shortfalls and actions were being taken to drive improvement.

Documentation was in place for the recording of incidents and accidents. This included the date, time, person and staff involved, details of the incident/accident, immediate action taken and the level of harm, such as minor injury or no harm. On a monthly basis, all incidents and accidents were collated and analysed for any trends, themes or patterns whilst also considering how improvements could be made following individual accidents and incidents. Following a recent choking incident, the registered manager demonstrated how learning had been derived from the incident and what actions had been implemented. For example, referrals made to the GP, Speech and Language Therapist (SALT) and care plans and risk assessments were subject to review.

Lydfords Care Home is part of a large, corporate organisation called Four Seasons. Four Seasons provide nursing care across England and have several nursing homes within the local area. The management team consisted of a registered manager and a deputy manager. The provider had a philosophy of care that stated 'We are committed to providing the highest possible standards of care. Residents will be treated as individuals and cared for with respect and dignity within a safe, comfortable and homely environment which provides stimulation and encourages independence where appropriate'. Staff spoke highly of the management team and confirmed they felt supported and valued within their role. Staff confirmed the registered manager was approachable and operated an open-door policy. People and their relatives knew the manager by her first name and people responded to the manager and deputy manager with smiles and presented as reassured and content in their presence. The management team had a clear presence within the service and throughout the inspection, they were observed interacting with people and their relatives.