

Country Court Care Homes 3 OpCo Limited

Lostock Lodge Care Home

Inspection report

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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

This inspection was carried out on 16 and 17 October 2018 and was announced on the first day and announced on the second day.

Lostock Lodge 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. Lostock Lodge is a purpose-built home offering accommodation and support for up to 66 people. At the time of our visit there were 42 people living at the home.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service had appointed a new manager following the resignation of the registered manager and they took up this post in April 2018.

During the last inspection on 28 February 2018 and 5 March 2018 we found that there were a number of improvements needed in relation to safe care and treatment, dignity and respect, staffing, training and competence, accidents and incidents, and good governance. These were breaches of Regulation 10, 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service was placed in special measures.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions Safe, Effective, Caring, Responsive and Well Led to at least good. The provider sent us an action plan that specified how they would meet the requirements of the identified breaches.

During this inspection we found all the required improvements had been made. The service has been removed from special measures.

Improvements had been made to the management and administration of medicines. We found that medicines were managed safely in accordance with good practice guidelines. Staff had received training and had their competency assessed.

Improvements had been made to the recording of accidents and incidents. Documents were consistently and fully completed and reviewed by the registered manager. Analysis took place to identify trends and patterns.

We found improvements had been made to the management and mitigation of risk. Records clearly identified areas of risk specific to the person and gave clear guidance that included the level of intervention

required for staff to follow to mitigate the risk to people.

Improvements had been made to the deployment of staff across the home. Sufficient staff were employed to meet the needs of the people supported. Staff were evenly deployed across the home to meet people's individual needs.

Improvements had been made to the consistent completion of induction of staff at the home. Staff employed since our last inspection had all undertaken an induction at the start of their employment. This included organisational induction and the completion of the Care certificate.

People told us that staff consistently treated them with respect and their dignity was respected.

The registered provider had improved the effectiveness of the quality assurance systems in place. Audits across many areas of the home were consistently completed. Action plans identified areas for development and improvement. The registered provider held bimonthly clinical governance meetings to overview the findings of all audits undertaken.

Safeguarding policies and procedures were in place. Staff had all received training and were able to describe what abuse may look like and actions they would take if they had any concerns.

People had their needs assessed before moving in to the home. This information was used to create person centred care plans and risk assessments. People's needs that related to age, disability, religion or other protected characteristics were considered throughout the assessment and care planning process.

Staff had developed positive relationships with people and demonstrated a good understanding of their individual needs. We observed positive interactions between staff and people that included comfortable conversations and banter.

People's food and drinks needs were met and clear guidance was in place for staff to follow to meet people's specific dietary needs.

People had the opportunity to engage in activities of their choice. People spoke positively about the activities available.

The Care Quality Commission is required by law to monitor the operation of the Mental Capacity Act (MCA) 2005 and report on what we find. We saw that the registered provider had guidance available for staff in relation to the MCA. Staff had undertaken training and demonstrated a basic understanding of this. Care records reviewed included mental capacity assessments and best interest meetings.

The registered provider had a complaints procedure in place and people told us they felt confident to raise any concerns or complaints.

Policies and procedures were available for staff to offer guidance within their role and employment. These were regularly reviewed and updated.

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 

The service was not always safe.

Improvements had been made to the management of medicines. However, sustained improvement could not yet be demonstrated.

The registered provider had safe recruitment practices in place and sufficient staff were employed to meet people's needs.

Risk assessments were in place that promoted people's independence and gave clear guidance to staff to mitigate risk.

Is the service effective?

Good 

The service was effective.

Staff all received training for their role and to meet the needs of the people they supported.

The registered provider followed the requirements of the Mental Capacity Act 2005.

People's food and drink needs were met. Clear guidance was in place for people with specific dietary requirements.

Is the service caring?

Good 

The service was caring.

Staff had developed positive relationships with people living at the home and had a good understanding of their needs.

People's privacy and dignity was respected and promoted.

People's communication needs were considered and supported. Staff had clear guidance available about how to meet these needs.

Is the service responsive?

Good 

The service was responsive.

People's care plans reflected their personal choices and staff were familiar with people's preferred routines.

Individual and group activities were available for people to participate in at the home. People spoke positively about the activities available.

The registered provider had a complaints policy and procedure in place. People told us they felt confident to raise any concerns they had.

Is the service well-led?

Requires Improvement 

The service was not always well-led.

Improvements had been made to the governance processes in place at the home to identify areas for development and improvement. Sustained improvement could not yet be evidenced.

The registered provider sought regular feedback from people and their relatives through meetings and questionnaires.

The registered provider had policies and procedures in place that were regularly reviewed and updated.

Lostock Lodge Care Home

Detailed findings

Background to this inspection

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

This was a comprehensive inspection carried out by two adult social care inspectors, a pharmacy inspector and an expert by experience with an interest in dementia. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

This inspection was unannounced on 16 October 2018 and announced on 17 October 2018.

Prior to the inspection the provider had completed a provider information return (PIR). This is a form asks the provider to give some key information about the service, what the service does while and any improvements they plan to make. We used this information as part of our inspection planning and throughout the inspection process.

As part of the inspection planning we reviewed the information the registered provider had given to the CQC since the last inspection. We looked at information provided by the local authority, safeguarding team and commissioning team. Feedback we received identified that improvements had been made at the home.

We checked the information we held about the registered provider and the home. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the home. A notification is information about important events which occur at the home that they are required to send us by law.

During the inspection we spoke with 16 people living at the home, four relatives of people living at the home, the registered manager, the area manager and four staff. We also spoke with a visiting health care professional. A short observational framework [SOFI] was undertaken. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed staff supporting people throughout our visit.

We looked at four care plan files, four staff recruitment and training files, medication administration records (MARs), complaints, policies and procedures as well as other records that related to the running of the home.

Is the service safe?

Our findings

People and their relatives spoke positively about Lostock Lodge and their comments included "I feel my mother is very safe in the home", "I came here because I had some falls and didn't feel safe at home, but I do here" and "I don't have to check the windows and doors like at home, staff are always around."

During our last inspection we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered provider had failed to ensure the safe management of medicines, accidents and incidents were not always clearly recorded, reported and investigated, some safeguarding concerns had not been raised and investigated and they did not have effective systems to identify and assess risks to the health and safety of people using the service.

At this inspection we found that improvements had been made across all required areas. We were not able to demonstrate sustained improvement.

Improvements had been made to the management and administration of medicines. We found that medicines were managed safely. Medicine cupboards were neat and clean and the medicines inside were kept at the right temperatures. However, minimum and maximum temperatures of the medicines refrigerator were not recorded to check that medicines requiring cold storage were kept at the right temperature throughout the day and night. This was raised with the registered manager who immediately addressed this. Arrangements for storing and recording medicines that are controlled drugs (medicines subject to extra control because of the risk of misuse) complied with the law.

We saw that staff gave people their medicines in a safe and friendly way. One person told us "I feel really looked after, and don't have to worry about getting my medication like at home, it's always on time here." Two senior carers told us their competency to administer medicines had been assessed before they were allowed to give medicines. The home's manager carried out monthly medicine audits. These checks had been effective in improving the way medicines were handled in the home.

We looked at the records of two people who had moved into the home recently and found that checks were carried out to make sure they received the right medicines. We looked at the medication administration records (MARs) for a further six people and saw that the receipt and administration of medicines were properly recorded. The disposal of medicines was also recorded so that all medicines could be accounted for. Two people were prescribed a liquid medicine for pain relief and when we checked this medicine we found that the amount in stock did not match the records for one person. The registered manager undertook an immediate investigation and the outcome was an administrative recording error.

Entries on (MARs) that were handwritten were signed by two members of staff to indicate the information had been checked. If a person was prescribed a cream or medicine patch additional records were kept that ensured the medicine was applied in the right way. Extra written guidelines (protocols) were in place for people's 'when required' medicines.

The home kept a stock of homely remedies (medicines that can be purchased from a pharmacy or other store without a prescription) for minor health conditions. These medicines were only given to people with their GP's prior consent.

Improvements had been made to the recording of accidents and incidents. Documents were consistently and fully completed and reviewed by the registered manager. This information was entered on to a spreadsheet and regular analysis undertaken to identify trends, patterns and areas of learning, development and improvement.

We found improvements had been made to the management and mitigation of risk. Records clearly identified areas of risk and gave clear guidance that included the level of intervention required for staff to follow to mitigate the risk to people. Risk assessments were in place for moving and handling, pressure area care, medicines, personal hygiene, falls, continence and cognition. This meant staff provided safe care and the correct level of intervention relevant to each person.

The registered provider continued to have safe recruitment practices in place. Each recruitment file included an application form, interview notes references that included the most recent employer and a disclosure and barring check (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

Improvements had been made to the deployment of staff across the home. We reviewed the staff dependency tool completed by the registered manager and found the home had sufficient staff in place to meet the needs of the people supported. Staff were evenly deployed across the home to meet people's individual needs. One relative told us "When I visit there are always lots of staff about who are very attentive."

The home had effective systems in place to safeguard people from abuse. Staff training was up-to-date and staff demonstrated a good understanding of this area. There was a clear reporting process in place that staff fully understood. Records showed safeguarding concerns had been appropriately raised and reported in line with local authority safeguarding policies and procedures.

People told us they sometimes had to wait for a while when they rang their 'call alarm'. We reviewed the records of the time staff took to answer these calls and found they were mainly answered within one minute. There were occasional times when a call had taken longer to be answered but records showed staff were already supporting other people that had used their 'call alarms' at the same time.

Daily health and safety walk rounds were undertaken and actions recorded and promptly addressed for any areas of concern highlighted. Cleanliness, tidiness, equipment, odours, hazards were all considered and recorded. All equipment continued to be regularly checked and serviced so it remained safe. All required safety certificates were in place. Fire safety checks were consistently completed and fire evacuations had been undertaken. All people living at the home had a personal emergency evacuation plan (PEEP) in place that described the level of staff intervention required to support them to evacuate the building in the event of an emergency.

All staff had completed infection control training and were able to describe the importance of following best practice guidelines. Staff used personal protective equipment (PPE) when undertaking personal care tasks to prevent the spread of infection. Lostock Lodge was clean, warm and comfortable with no odours present.

Is the service effective?

Our findings

During our last inspection we found a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered provider had failed to ensure all staff completed the Care certificate and undertake regular competency assessments in accordance with their policy.

At this inspection we found that the above requirements had been met.

Improvements had been made to the consistent completion of induction of staff at the home. Staff employed since our last inspection had all undertaken an induction at the start of their employment. This included an organisational induction where they learnt about their role, essential information about working in the home and about policies and procedures in place. They also completed the care certificate which is a nationally recognised qualification based on a minimum set of standards, that social care workers follow in their daily working life. The standards give staff a good basis from which they can further develop their knowledge and skills. Staff completed shadow shifts to gain a good understanding of people's individual needs. Staff undertook training relevant to their role along with refresher updates in accordance with good practice guidelines. Staff had their competency checked and also their practice was regularly observed.

Staff undertook supplementary training that had recently included dementia mental health, end-of-life care, stroke awareness, prevention and management of pressure sores, diabetes and dignity. This meant staff had the additional knowledge and skills required to meet the needs of people living at the home.

Staff told us they felt well supported by senior staff and the management team. Staff undertook regular supervision with their line manager and had an annual appraisal in accordance with the registered providers policy and procedure.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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 checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. We found that they were.

The home operated in accordance with the principles of the mental capacity act 2005 (MCA). Discussions with people confirmed that their consent was sought in relation to care and treatment and records

supported this. Comments from people included "Staff support and encourage me to make lots of choices every day. These include choosing my own clothes, drinks, activities and where I would like to spend my time. Staff never undertake any task without me saying it's okay first."

Care records showed that people living at the home had visits from healthcare professionals as needed. Visits were clearly documented, including the reason for the visit and any actions or changes to the care plans. Relatives were informed of health professionals visits to keep them updated.

Staff undertook regular checks of people throughout the day and night. These included repositioning records for people supported in bed, well-being checks well people were in their bedrooms and nutrition and hydration charts. People were consistently checked in accordance with their care plan requirements.

People were supported to eat and drink in accordance with their assessed needs. Tables were laid in the dining room with crockery, cutlery, cruet and serviettes. People were invited to sit in place of their choice. People were offered a drink of their choice that included wine, beer, juice, lemonade or other alternatives were available.

Staff offered alternatives to a person that changed their mind about their previous choice and the chef prepared an alternative meal of a jacket potato when a person decided they did not want what was on the menu. Staff not sat next to a person that required support to eat. They supported them at a pace appropriate to meet their need.

The mealtime experience was positive overall as we observed lovely, comfortable conversation between people and staff. People's comments included, "The food is good and well cooked, the chef comes round and talks to us, it's good to have that personal touch", "The food has improved in the last couple of weeks", "They are very good at catering for my special diet and allergies, nothing is too much trouble", "The food is varied and very well cooked", "You can have whatever you want, there is always a choice" and "They bring tea and biscuits when we visit, and there is a separate dining room we can use for family meals."

Is the service caring?

Our findings

We received very positive comments from the people living at Lostock Lodge about the staff that supported them. They described staff as caring, kind, polite and considerate. Comments included, "The staff pay attention to the little things and are very good", "Everyone is very kind", "I feel respected, despite my speech problems they do not treat me like an idiot", "Nothing is too much trouble and staff are always cheerful" and "I am fully consulted regarding my care and always asked before being assisted."

During our last inspection we found a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were not consistently treated with dignity and respect.

At this inspection we found improvements had been made in this area.

People told us that staff consistently treated them with respect and their dignity was respected. Examples included, "Staff call me Mrs [Name] as this is my preference", "Staff call me by my preferred name which is not my birth name", "Staff always knock and wait for me to answer before they enter my room" and "Staff keep the bedroom door closed while they are dressing or undressing me."

Staff had a very good understanding of the people they supported. They were able to describe people's likes and dislikes, their histories, family members, interests and hobbies. We observed staff having comfortable conversations with people and talking about topics that they were interested in.

People's care plans held information about their individual communication needs. Information was included about any sensory loss along with clear guidance for staff to ensure people's needs were met. One person's care plan described the importance of them wearing their glasses at all times. The provider arranged regular eye tests and ensured their prescription remained up-to-date to meet their individual needs. Staff described the importance of ensuring people's glasses or hearing aids were in place to support and encourage them to communicate fully.

People and their relatives described the different ways that they were offered choice. Examples included "My mum can choose whether to sit with company or in a quiet space, whether to eat in the dining room or her bedroom and what activities she would like to participate in", "I like to choose my own clothes as I am very particular about things matching", "My choices can be as simple as whether I would like tea or coffee but this is important to me."

Staff described the importance of encouraging and promoting people's independence. They described supporting people to do whatever they could for themselves. For example, allowing additional time for a person to undertake their personal care routine with support and encouraging people to dress or undress themselves offering support with zips and buttons. They described the importance of not just completing tasks for people as this would be removing their independence.

People told us their confidentiality was respected by staff. They described staff talking to them in their bedrooms with their door closed and they appreciated this. They described not always wishing to discuss any concerns or worries they had amongst other people living at the home and said staff understood and respected this.

People's records were stored securely within a locked office to maintain their confidentiality. Daily records and other important documentation were completed in private to protect people's personal information.

Records clearly included when a person did not wish to be resuscitated in the event of their death. This information was readily available for all staff and visiting healthcare professionals.

Is the service responsive?

Our findings

During our last inspection we made a recommendation that the service find out more about activities for people at the service, based on current best practice, in relation to the specialist needs of people living with dementia. At this inspection we found improvements had been made in this area.

People spoke positively about the activities available within the home. Their comments included "There's always something going on including trips out", "I sometimes come out of my room in the afternoon but mostly I like my own company", "Looking forward to going to Blackpool if we can arrange it" and "I have a different lifestyle altogether, I feel really looked after and my life is full."

People described different ways that they spent their time. Activities included, karaoke, local school children visited, quizzes, listening to music and having sing-a-longs, reading, they helped look after and feed the two pet rabbits that people had named Roger and Peter. One person said, "We like to go out and see what the rabbits are doing." One person told us they had a newspaper of their choice delivered every day and people took it in turns to deliver these to each other. A petting dog called Arthur visited each week and people told us they looked forward to this.

The library at the home had a selection of fiction and non-fiction books that included large print and audio. There was a nail spa where people could have their nails manicured and polished. A family room was available that had a TV, games and a seating area that relatives told us was very useful when they visited with children as this helped to keep them entertained. There was a cinema room which had 10 comfortable seats where people could sit and relax to watch a film of their choice.

During our visit we saw staff members reading with people and engaging in comfortable conversation. People were playing jenga, scrabble, completing crosswords, listening to music and having a sing-a-long.

People had their needs fully assessed before they moved into the home. Staff that completed these assessments had received training to ensure they were competent at this task. The information from the assessment was used to develop person centred care plans and risk assessments. People's needs in relation to equality and diversity were considered throughout the assessment and care plan development process. These needs included age, disability, religion and other protected characteristics. People and their chosen relatives told us they had been included in the development of the care plans.

During our last inspection we found people's care plans did not always reflect their needs. We found at this inspection that care plans were specific to each person and held sufficient detail and guidance for staff to follow to fully understand each person's individual needs and choices. People's preferred routines were detailed and included their individual preferences. For example, the time they liked to get up in the morning or go to bed, if they liked a hot milky drink at bedtime, if they preferred a shower or a bath and what time of day they liked these. Helpful information and guidance for staff was held within the care plan files. For example, fact sheets about diabetes and insulin. All care plans and risk assessments were reviewed regularly and updated as and when any changes occurred.

We reviewed people's end of life care plans. Where people had expressed any preferences, these were clearly documented. Staff had received end-of-life training and told us the importance of keeping people comfortable, treating them with dignity and respect. They also described the importance to include people's chosen family and friends at this time.

Daily records were consistently completed and included information about personal care, continence, activities, medicines and diet. Observational charts were consistently completed as well as food and fluid charts and other records required to meet individuals assessed needs.

Is the service well-led?

Our findings

During our last inspection we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During our last inspection we found ongoing concerns that the registered provider was in breach of regulations. Leadership within the service was ineffective, improvements to quality and safety were not identified, audits were not effective and accidents and incidents were not always recorded.

At this inspection we found that improvements had been made across all required areas. We were not able to demonstrate sustained improvement.

The home had a registered manager who had been registered with the Care Quality Commission since August 2018. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered provider had improved the effectiveness of the quality assurance systems in place. They were consistently completed to assess and monitor all areas of the service. These included audits undertaken by the registered manager, staff and representatives of the registered provider. This included the areas of care plans, medicines, staff training and supervision, environment, incidents and accidents, infection control and record-keeping. Action plans were created following the audits and these were signed off when actions had been completed. The registered provider held bimonthly clinical governance meetings to overview the findings of all audits undertaken. They are used this information to continually develop and improve the service.

People and their relatives were regularly invited to share their views about the home. Residents' and relatives' meetings were held regularly where the registered manager overviewed areas that were being improved and developed. They also welcomed ideas, suggestions and feedback. A recent discussion had included the introduction of a residents committee to participate in staff recruitment. This idea had been embraced and a number of residents were undertaking training to support them to participate in staff recruitment processes. One person told us "It's important we are included in recruitment as the staff are working with us. It is also a good activity to keep me occupied." People and their relatives were also invited to complete quality questionnaires. The information from these was collated by the registered provider to identify any areas for development and improvement.

Staff meetings were held bimonthly and minutes were taken. The registered manager discussed key topics that included organisational systems, importance of documentation completion and offered staff the opportunity to share ideas for improvement and development. The minutes were shared with staff not in attendance on that day. Staff also attended daily handovers to keep up-to-date with any changes in people's needs or requirements of their role. Staff told us the communication across the home was really good. Staff told us they felt listened to and their ideas were welcomed.

Staff spoke positively about their roles and demonstrated enthusiasm about making a positive difference to people's lives. Staff told us that the management team were approachable and they did listen to any concerns they had. Staff told us they felt well supported and gave individual examples of support they had received professionally and personally.

The registered provider had a comprehensive set of policies and procedures that were regularly reviewed and updated. These gave staff clear guidance in all areas of their work role and employment.

Registered providers are required by law to inform the Care Quality Commission of certain incidents and events that had occurred within the service. The service had notified the CQC of all significant events which had occurred in line with their legal obligations.