Premierbell Limited

Homer Lodge Care Centre

Inspection report

23-26 Monson Street
Lincoln
Lincolnshire
LN5 7RZ

Tel: 01522530108
Website: www.halcyoncare.co.uk

Date of inspection visit:
21 September 2016

Date of publication:
28 November 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 21 September 2016 and was unannounced. Homer lodge provides care for older people who have mental and physical health needs. It provides accommodation for up to 47 people who require personal and nursing care. At the time of our inspection there were 30 people living at the home.

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.

On the day of our inspection staff interacted well with people. People and their relatives told us that they felt safe and well cared for. Staff knew how to keep people safe. The provider had systems and processes in place to keep people safe. However risk assessments had not always been completed. We have made a recommendation about the use of slings.

Medicines were not consistently administered safely. We saw that staff obtained people's consent before providing care to them. The provider acted in accordance with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. If the location is a care home the Care Quality Commission is required by law to monitor the operation of the DoLS, and to report on what we find. We have made a recommendation about MCA & DoLS.

We found that people's health care needs were assessed and care planned and delivered to meet those needs. People had access to healthcare professionals such as the district nurse and GP and also specialist professionals. People had their nutritional needs assessed and were supported with their meals to keep them healthy. People had access to drinks and snacks during the day and had choices at mealtimes. Where people had special dietary requirements we saw that these were provided for.

There were sufficient staff to meet people's needs and staff responded in a timely and appropriate manner to people. Staff were kind and sensitive to people when they were providing support. People did not always have their dignity considered. Staff were provided with training on a variety of subjects to ensure that they had the skills to meet people's needs. The provider had a training plan in place and staff had received regular supervision. People were encouraged to enjoy a range of social activities. They were supported to maintain relationships that were important to them.

Staff felt able to raise concerns and issues with management. Relatives were aware of the process for raising concerns and were confident that they would be listened to. Regular audits were carried out and action plans put in place to address any issues which were identified. The process had failed to identify some of the issues we found at inspection. Accidents and incidents were recorded and investigated. The provider had

informed us of notifications. Notifications are events which have happened in the service that the provider is required to tell us about.

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 consistently safe.

Medicines were not administered safely.

Risk assessments were not always completed.

There were sufficient staff to provide safe care.

Staff were aware of how to keep people safe. People felt safe living at the home.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The provider did not act in accordance with the Mental Capacity Act 2005.

Staff received regular supervision. Not all staff had received training to support them to meet the needs of people who used the service.

People had their nutritional needs met.

People had access to a range of healthcare services and professionals.

Is the service caring?

Requires Improvement

The service was not consistently caring

People did not have their dignity consistently considered. Care was not always provided in an appropriate manner.

Staff responded to people in a kind and sensitive manner.

People were involved in planning their care and able to make choices about how care was delivered.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care records were not personalised.

People had access to activities and leisure pursuits.

The complaints procedure was on display and people knew how to make a complaint.

People were aware of their care plans.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There were some systems and processes in place to check the quality of care and improve the service however checks had not identified the issues we found on inspection.

Staff felt able to raise concerns.

The registered manager created an open culture and supported staff.

Homer Lodge Care Centre

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.

This inspection took place on 21 September 2016 and was unannounced. The inspection was completed by an inspector, an expert by experience and a specialist advisor. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Specialist advisors have expertise in specific areas of care relevant to the service being inspected.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Before the inspection, the provider completed 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 what improvements they plan to make. We used this information to help plan our inspection.

We also looked at notifications which we held about the organisation. Notifications are events which have happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies.

During our inspection we observed care in the home and spoke with the registered manager, two nurses and two members of care staff. We spoke with six people who used the service and four relatives. We also looked at six people's care plans and records of staff training, audits and medicines.

Requires Improvement

Is the service safe?

Our findings

We observed the medicine round and saw that medicines were not always administered safely. One person told us their medicines were always on time but staff left them with them to take when they were ready. Another person said, "I take four pills in the morning. One nurse puts them in my mouth and waits, others leave the pot with me to take later." We observed staff leaving medicines with people on four occasions during the medicine round. When we asked a nurse about this, they said the person was able to take their medicines independently and they were watching them from a distance (while they continued with the medicines round). We asked if the other people at the table could be relied on not to take the person's medicines and they said they would see that, if it happened and prevent it. However, they were not close enough to the table to have been able to have prevented it. We did not see the nurse return to the person to check they had taken their medicines which meant they had signed that the medicines had been taken when they could not be sure they had and they could not be sure the person was not storing their medicines rather than taking them. Risk assessments had not been completed to assess the risk of people being left with their medicines. There was a risk that people did not receive the prescribed medicines and that other people could access inappropriate medicines.

Protocols for medicines which are given as required (PRN) such as painkillers, were not in place to indicate when to administer these medicines and whether or not people could request and consent to having their medicines. People were at risk of receiving medicines inappropriately. People were asked if they wanted their PRN medicines during the medicine round. We saw that the medication administration records (MARS) had been fully completed however this was not always according to the provider's policy and guidance as we observed medicines being signed for without assurance that people had taken them. Medicines were stored in locked cupboards according to national guidance. Processes were in place to ensure that medicines were disposed of safely and records maintained regarding stock control.

This was a breach of Regulation 12(2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Policies and procedures were not followed to ensure medicines were administered safely.

Individual risk assessments were completed on areas such as nutrition and skin care. However, we found the pressure ulcer risk assessment for one person had not been fully completed as the section for their weight and Body Mass Index (BMI) had not been completed. We also found their moving and handling assessment had not been completed, although their mobility care plan stated they could walk short distances with the assistance of two staff. Risk assessments were not in place in the care records we reviewed for bed rails.

People who used the service told us they felt safe living at the home and had confidence in the staff. A person said, "I feel safe, it's a safe environment here." Another person said, "I feel fine and well looked after. On the medical side, it's excellent." Relatives told us that they felt their family member was safe. One relative said, "[Family member] is safe and looked after well." People and relatives told us that there was usually enough staff to provide safe care to people. A relative said, "We always manage to find someone and have no worries on staffing." One person said, "I think there's enough to see to all our needs" and another said, "From time to time they're very short, especially due to holidays or pregnancies."

Care staff said that they thought on occasions there was not enough care staff but it depended on people's needs. They said if they required support both the nurses and registered manager would provide assistance in order to meet people's needs. We observed staff responded to people promptly. The registered manager told us that staffing levels varied according to the needs of people. Since our previous inspection the provider had employed staff with a range of skills in order to meet the needs of people who lived at the home.

The registered provider had a recruitment process in place which included carrying out checks and obtaining references before staff commenced employment. They also carried out Disclosure and Barring Service (DBS) checks to ensure that prospective staff would be suitable to work with the people who lived in the home. These checks ensured that only suitable people were employed by the provider.

Staff were aware of what steps they would take if they suspected that people were at risk of harm. They were able to tell us how they would report concerns, for example, to the local authority. Staff told us that they had received training to support them in keeping people safe. The registered provider had safeguarding policies and procedures in place to guide practice and we had evidence from our records that issues had been appropriately reported.

Accidents and incidents were recorded and investigated to help prevent them happening again. For example, falls were monitored and actions had been put in place on an individual basis to reduce the risk of falls to people. Individual plans were in place to support people in the event of an emergency such as fire or flood. We saw where the response to a fire drill had been unsatisfactory by staff additional support and training had been put in place to ensure that in future staff were more responsive to the fire alarm.

Requires Improvement

Is the service effective?

Our findings

The provider did not act in accordance with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interests decision is made involving people who know the person well and other professionals, where relevant. We saw that best interests decisions had been carried out however these were not specific as to what decisions these related to. For example, a person required bed rails to be in place but the best interests decision did not detail this. There was a risk that decisions were not being taken in people's best interests.

A do not attempt cardiopulmonary resuscitation (DNACPR) was in place for a person, however although it stated the order had been discussed with the person to assist them to understand an MCA assessment carried out at an earlier date stated that the person lacked capacity. The DNACPR had not been reviewed to reflect the person's change in capacity and a best interest decision had not been made to support this.

We recommend that the provider ensures that they are familiar with current legislation in relation to MCA and DoLS.

We observed that people were asked for their consent before care was provided. Records included completed consent to treatment forms and consent to photography to ensure that care was provided with people's consent. Consent forms were not in place for people who used specialist equipment such as bed rails. Where people were unable to consent this was detailed in the care records however it was not always clear what support people required and why.

If the location is a care home the Care Quality Commission is required by law to monitor the operation of the DoLS, and to report on what we find. At the time of our inspection there was no one who was subject to DoLS, although applications had been made and the provider was awaiting the outcomes of these. DoLS provides legal protection for those vulnerable people who are, or may become, deprived of their liberty. When we spoke with staff about the MCA and DoLS they were able to tell us about it and how it applied to people within the home.

One person told us, "I think they're very well trained. I see new ones shadow." Staff told us they were happy with the training that they had received and that it ensured that they could provide appropriate care to people. However we saw from the training records that only three staff had received training about skin care and similarly for end of life care only four people were recorded as completing this. We saw from the training records that only a small number of staff had received training on areas which were specific to people's care needs such as dementia care, diet and nutrition and catheter care. Most staff had received training on core areas such as fire and moving and handling.

We spoke with two nurses who felt they had the opportunity to undertake training when they identified a training need. For example, one nurse told us they had identified the need to undertake urinary catheterisation training and a course was planned for the following month. However, there were no regular

planned clinical updates for nursing staff on issues such as wound management and specialist nutrition. One of the nurses had a bank contract with the home and worked in the NHS as well. They told us they had undertaken some mandatory training at the service and they had completed other training some of which was provided by the service but most had been completed with their other employer. They had not been asked to provide any training certificates to evidence their training elsewhere. They told us the service had been supportive in helping them to prepare for re-validation. Re-validation is the mechanism for nurses to renew their professional revalidation which requires evidence of training and support.

There was a system in place for monitoring training attendance and completion for permanent staff. It was clear who required training to ensure that they had the appropriate skills to provide care to people and that staff had the required skills to meet people's needs. Staff also had access to nationally recognised qualifications. New staff received an induction and when we spoke with staff they told us that they had received an induction and found this useful. The induction was in line with national standards.

Staff were happy with the support they received from other staff and the registered manager of the service. They told us that they had received regular support and supervision and that supervision provided an opportunity to review their skills and experience. We saw that appraisals were in the process of being carried out. Appraisals are important as they provide an opportunity to review staff's performance and ensure that they have the appropriate skills for their role.

We observed lunchtime and saw staff assisting people with their meal to ensure that they received sufficient nutrition. Staff sat alongside people and chatted as they supported them. The lunchtime meal was relaxed with staff serving the meals and engaging in conversation with people. People were offered a choice of two meals. One person said, "It's very good and we get a choice. They offer us a piece of fruit now and then." Staff told us if people did not want the offered meals or the meal they had chosen they were able to provide alternatives.

People had been assessed with regard to their nutritional needs and where additional support was required appropriate care had been put in place. For example, people received nutritional supplements to ensure that people received appropriate nutrition. Where people had allergies or particular dislikes these were highlighted in their care plans.

A person told us, "There are always drinks on the go. I have water in my room too." We observed people were offered drinks during the day according to their assessed needs. However we observed one person who was having a drink, was supported to move out of the lounge area to sit in another area at their request. However staff failed to take their drink with them despite the fact the person had not had opportunity to finish their drink. When we checked care records we found the person was at risk of infection due to lack of fluids. The person was at risk of receiving insufficient fluids. Staff were familiar with the nutritional requirements of people and records of food and fluid intake were maintained appropriately.

We found that people who used the service had access to local and specialist healthcare services and received on-going healthcare support from staff. Where people had specific health needs such as diabetes information was available to staff to ensure that they provided the appropriate care. During our inspection we observed people being seen by visiting health professionals. Care plans were also in place for short term health issues such as infections.

The home worked closely with the Independent Living Team (ILT) and transitional care. (These are teams which provide additional short term support to enable people to return to their home). A nurse from the team was based at the service and other members of the multi-disciplinary team visited the service daily. We

were told there was a weekly meeting with nurses, a physiotherapist and occupational therapist and the ILT for people admitted under the ILT. Staff received daily handovers where they discussed what had happened to people on the previous shift and their health and wellbeing. Where people had specific needs such as physical health issues advice was included in the record about how to recognise this and what treatment or support was required. This helped staff to respond to people's needs.

Requires Improvement

Is the service caring?

Our findings

People who used the service and their families told us they were happy with the care and support they received. One person said, ""They know me very well." Another person said, "They're very caring, especially if you're not well." Relatives confirmed they thought the staff were kind, courteous and treated the residents with respect. All the people we spoke with said that they felt well cared for and liked living at the home.

A professional who visited the home regularly said they felt one of the strengths of the home was that, staff were really caring. They said they received good feedback about the staff from people using the service who they visited.

We observed that staff were aware of respecting people's needs and wishes. One person told us, "I go to bed at 7pm and decide when to be up. I'm often last about 11am though so I get breakfast in bed before. I sit where I like in the lounge." We observed a person was sat in a hard chair in the dining area and staff spoke with them about whether or not they were comfortable and offered to support them to move to a more comfortable area. The person refused initially and staff accepted this but offered them a drink. When they returned with the drink they took time to ask again if they would like to move and explain the benefits of sitting in a different chair. The person then agreed to move and chose where they wanted to move to.

We saw that staff interacted in a positive manner with people and that they were sensitive to people's needs. For example, on the day of our visit we observed four members of staff writing in records whilst sat in the dining area at a table with a person who lived at the home. Three of the staff members chatted with the person about day to day things such as their family and when they were visiting.

Staff supported people to mobilise at their own pace and provided encouragement and support. For example, we saw a person walking with a staff member and the staff had a supportive arm on their back to give reassurance whilst they were walking. We saw when staff supported people to mobilise by using specialist equipment they explained what they needed people to do and explained what was happening. However a person asked to be assisted from the room and a member of staff brought a wheelchair which they placed facing the person. They encouraged the person to push themselves up using the arms of the chair they were sitting in (correctly) but then they encouraged them to steady and support themselves using the arms of the wheelchair which was not at the correct height for the person and they then had to turn 180 degrees to sit in the wheelchair. The person was at risk of falling.

We observed a person sitting in a lounge chair had not had their moving and handling sling removed and it remained in place for the time the person was in the lounge. We also observed the same person sitting in their wheelchair in another lounge after lunch, again with the sling in place. We talked with a member of staff who said it was very difficult to remove the sling as the person had limited movement and the sling was a full body sling. Leaving the sling in place increases the risk of pressure ulcers and is not dignified for the person. However, in circumstances where slings cannot be moved, specific slings designed to be left in place could be used. We observed two other people sitting in wheelchairs at the dining table with the moving and handlings slings still in place.

We recommend that the provider seeks guidance on the use of moving and handling equipment and managing dignity.

People who used the service told us that staff treated them well and respected their privacy. People told us and we observed that staff knocked on their bedroom doors. One person said, "They knock and just come in." A relative told us, "They're always polite to people." We saw that staff addressed people by their preferred name and that this was recorded in the person's care record. Staff had been asked to be involved in assessing the service against national guidance for dignity and we saw that this had been discussed at a staff meeting. However we observed that staff did not always treat people in a dignified manner. For example before supporting people to go for lunch staff asked people in an indiscreet manner if they required support with their personal care. They also shared between themselves but in a manner that could be overheard who had already received this support. At lunchtime we observed that everyone was given an apron to wear rather than asking if they would like to wear an apron. People's dignity was not maintained.

Requires Improvement

Is the service responsive?

Our findings

Activities were provided on a daily basis. Staff told us they felt there was a good level of activities for people. One staff said, "There's regularly things going on and there are trips out. They have been to the seaside recently." They told us the care staff helped with activities when the activities staff were on holiday. We saw that a staff member spent time in the afternoon encouraging several residents to play dominoes. Apart from this the only other entertainment was the TV which remained turned on throughout the day although few people appeared to be watching it.

A person told us, "We've got an Elvis singsong soon. We tell them if we want something planned. We went to Mablethorpe on a minibus and had fish and chips and ice cream, wonderful!" Another person said, "We have parties and [activity coordinator] gives us a bit of sherry, we've an Elvis party next. I read a lot upstairs, most of them are asleep in the lounge so activities are later on. We usually play games like scrabble." A relative told us, "There's a list on the door of what's on. They had an ice cream van. Singers come in too." People also had access to church services within the home and we saw that any specific cultural wishes were recorded in care records.

Care records were not personalised and focussed on practical support. Care records did not include detail so that staff could understand what things were important to people such as information about people's past life experiences and their preferances. Information such as this is important because it helps staff to understand what is important to people and why. For example, a care record outlined the parts of the person's personal hygiene they could complete themselves and parts they required assistance with, however, it did not provide any information about their preferences for things such as their clothing and the use of toiletries. It stated, "Offer bath or shower weekly," and did not state which they preferred (if they had a preference) or how frequently the person normally liked to have a bath or a shower. We noted another person's assessment identified they had a 'recent change in appetite' but gave no further information about this or explanation about the reason. Their nutrition care plan stated they were not on supplements but gave no other personalised information about their nutritional needs and the care plan had not been completed with their weight and BMI.

When individual care plans had been written for specific health issues these contained a good level of information about the physical care. For example, a care plan for a person who had a skin wound included details of the wound and type of dressing used. When people had a urinary catheter in place details of the requirements for care of the catheter and the frequency of catheter changes was recorded and we found a record of changes had been kept along with the batch numbers as required.

Care plans had been reviewed and updated with people who used the service. A person told us, "They always tell me how I'm doing and update my care book." One person said, "Exactly personal [care] and they will listen if I want something done differently or need an appointment made. "One person was unable to communicate verbally due to their physical disability and arrangements were in place to support staff to communicate with them by using written communication. Another person was unable to speak English however important words and phrases were available to staff to support them with communication.

Relatives told us that they felt welcome at the home and that they were encouraged to visit so that relationships were maintained. We observed staff offering visitors a drink and chatting with them and their family member.

A complaints policy and procedure was in place and on display in the foyer area. At the time of our inspection there was one ongoing complaint. The complaints procedure was only available in a written format. This could result in a lack of accessibility to people with poor reading skills, however at the time of our inspection most people were able to access this. Where complaints had been made and staff were involved in the complaint staff were supported to speak with the complainant about their concerns to get a better understanding of the issues and how it affected people. Complaints were monitored for themes and learning.

Requires Improvement

Is the service well-led?

Our findings

The registered manager told us that in order to understand first hand how care was being delivered they regularly worked with staff to provide care and staff confirmed this. They also attended the handovers in order to ensure they were kept updated on people and issues. Despite this when we spoke with the registered manager they were unaware of some of the issues we had identified at the inspection. For example, they were unaware of the issues with the administration of medicines and poor moving and handling practices. Although reviews were carried out on care records they were not aware that risk assessments and consent documents were not consistently available in care records.

Although arrangements were in place for checking the quality of care we found that these arrangements did not always ensure that appropriate care was provided. For example, a person should have been weighed on a monthly basis and we saw that the record detailed this until February 2016. After this period no further weights had been recorded until August 2016 (a gap of 6 months) at which point it was identified they had lost one stone in weight. It was not clear from the record if weights had been taken inbetween and the gap in the record had not been identified. This meant the weight loss was advanced before it was identified. The provider had put a process in place to carry out checks on the service and actions to improve quality of care, however this process had not consistently identified some of the issues we found at the inspection such as the inconsistency of records.

We found that despite interventions by the provider improvements had not consistently happened. For example, following our last inspection discussions had taken place with regard to privacy and dignity because we had highlighted concerns about this. Staff had been asked to assess the service against national standards for dignity. Despite this work we still observed that staff did not always treat people with dignity.We spoke with the registered manager about the lack of dignity we observed during lunchtime on the day of inspection. Despite being aware of this on the day they had chosen not to intervene at the time allowing people to be addressed inappropriately.

This was a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Systems were not operated effectively to ensure people received good quality care.

People felt the home was well run and told us all of the management team were approachable. One person said, "[Registered manager] comes and asks if we're happy, you could talk to them and know they'd do something." Another told us, "[Registered manager] been in today, we call her Matron and she chats to us." A relative said, "When we've spoken to the nurses, they ask our opinions on how [family member] looks and seems to us."

Staff understood their role within the organisation and were given time to carry out their role. They said they felt supported in their role and that staff worked as a team in order to meet people's needs. The registered manager had put in place arrangements to ensure that staff understood their roles and duties. For example staff were allocated on a daily basis to each floor but all staff worked across both units to ensure that there

was sufficient skilled staff to provide care to people. We saw that there was also a system in place to allocate responsibilities on a daily basis such as ensuring that people had sufficient fluids. Staff and relatives told us that the registered manager and other senior staff were approachable and supportive. Staff said that they felt able to raise issues and felt valued by the registered manager and provider.
A staff member told us they were able to ask the nursing staff for advice and assistance. They told us that staff meetings were held and if there were specific issues which needed discussing additional meetings would be arranged.

The service had a whistleblowing policy and contact numbers to report issues of concern, were displayed in communal areas. Staff told us they were confident about raising concerns about any poor practices witnessed. They told us they felt able to raise concerns and issues with the registered manager. The provider had informed us about accidents and incidents as required by law.

Resident and relatives' meetings had been held on a regular basis. We saw from the minutes of a meeting held issues such meals had been discussed. People we spoke with were aware of the meetings. Surveys had been carried out with people, their relatives and professionals and positive responses received. Relatives told us that they had completed surveys. We saw that following the surveys actions had been put in place to address any issues raised. The registered manager told us that they encouraged people and staff to come and speak with them at any time. In addition the registered manager had implemented a system where people who stayed for short periods of time were asked to complete a questionnaire a few days after admission and again following discharge to try and understand people's experiences of the service. They told us that these are collated on a monthly basis and the results shared with staff. We saw evidence of this at our inspection.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment This was a breach of Regulation 12(2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Policies and procedures were not followed to ensure medicines were administered safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance This was a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Systems were not operated effectively to ensure people received good quality care.