

Trees Park (Kenyon) Limited

Kenyon Lodge

Inspection report

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Ratings

Overall rating for this service

Requires Improvement



Is the service safe?

Requires Improvement



Is the service effective?

Requires Improvement



Is the service caring?

Good



Is the service responsive?

Requires Improvement



Is the service well-led?

Requires Improvement



Overall summary

This unannounced inspection was carried out on the 19 and 20 May 2015.

Kenyon Lodge provides nursing and personal care for up to 60 people. The single room accommodation is arranged over two floors and has lift access. A car park is available and the home is close to bus routes and a motorway network.

There was no registered manager in place at the time of our inspection. However, a new manager had been appointed who had previously worked as the deputy manager at the home and was very knowledgeable about

of all aspects of the service. They were currently applying to register with CQC as the registered manager for the service. 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 a 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 inspection carried out in April 2014, we identified concerns in relation to the management of

Summary of findings

medication and assessing and monitoring the quality of service provision. We undertook a follow-up Inspection in August 2014 to ensure the service had implemented improvements and found that the service had addressed those concerns.

During this inspection, we found two breaches of Regulations under of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Without exception, every person we spoke with told us they either felt safe or believed their family member was safe living at Kenyon lodge. One person who used the service told us; “I feel safe living here. No concerns at all.” Another person who used the service said “I’m quite happy and I do feel safe. The staff are lovely and look after me.”

As part of this inspection we checked to see how the service managed medication safely. We looked at a sample of 14 medication administration record (MAR) charts. We found that photographs were not always in place to ensure medicines were administered to the right people. The MAR sheets for people who resided in the Nursing Unit were reviewed and signatures omissions were found in seven records. This meant we could not be certain that medicines were administered in line with their prescription.

From examination of records we found evidence of topical cream recording charts for people were in place and were kept in people’s rooms. However, instructions recorded on the MAR by the pharmacist were not always accurately duplicated to the records maintained in people’s bedrooms. For example, in one instance pharmacist instructions clearly stated that ‘cream should be applied when required,’ while the instructions in the bedroom stated ‘apply after each wash.’

We found examples of where creams had been prescribed to people, however we found no records to indicate that the creams had been administered. This meant it was not possible to tell if a course of treatment had been administered correctly.

We found two examples of eye drops that had been opened, where the manufacture’s instruction clearly

stated that the medicine should be discarded after 28 days. No date of opening had been recorded on the package to ensure staff could follow the manufacturer’s instructions safely.

On completing a stock control of the controlled drugs we found that a person had two supplies of exactly the same medicine, which were documented in two different areas of the Controlled Drugs Register. This double entry had the potential to cause the person harm as the drug count would depend on the stock balance that staff used at the time.

We found that the registered person had not protected people against the risk of associated with the safe management of medicines. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, with regards to safe care and treatment.

We looked at the training staff received to ensure they were fully supported and qualified to undertake their roles. We looked at training records and found that less than half of staff at the home had completed their annual e-learning in relation to safeguarding and less for the Mental Capacity Act (MCA). Training records also demonstrated that a number of staff were overdue training in a number of training areas including fire awareness, manual handling and infection control. One member of staff said “We have to do training in own time, but I’ve been here twelve months and have not received any manual handling training. I don’t feel I’m getting much personal development.”

We looked at supervision and annual appraisal records and spoke to staff about the supervision they received. We found that not all staff were receiving regular supervision. One member of staff told us; “I don’t have regular supervision, I think it’s because we are short of a deputy manager.” Another member of staff said “I have not received any recent supervision.”

We found that the registered person had not ensured all staff received appropriate professional development and supervision. This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to staffing.

Summary of findings

We checked to see how people who lived at the home were protected against abuse. We found people were protected against the risks of abuse because the home had a robust recruitment procedure.

We looked at whistleblowing instructions kept within the manager's office, which contained the contact details of the manager, the regional manager, social services, clinical commissioning group and CQC. Staff were encouraged to report any concerns they had regarding poor practice or abuse. However, some staff we spoke with had limited knowledge regarding the principles and aims of safeguarding vulnerable adults.

We found the service undertook a comprehensive range of risk assessments to ensure people remained safe.

We looked at how the service ensured there were sufficient numbers of staff on duty to meet people's needs and keep them safe. We looked at staffing rotas and a dependency tool used by the service to determine staffing levels. On the day of our inspection, we found the atmosphere was calm and there were sufficient numbers of suitably qualified staff on duty to meet people's needs. On the whole, people we spoke with told us they thought that there was enough staff on duty throughout the day to meet their needs, but raised concerns about staffing levels at nights and weekends.

The Care Quality Commission has a duty to monitor activity under the Deprivation of Liberty Safeguards (DoLS). The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. We saw there were procedures in place to guide staff on when a Deprivation of Liberty Safeguards (DoLS) application should be made. However, some staff demonstrated a very minimal understanding around the principles of Mental Capacity Act (MCA) with regards to DoLS and reported that they had not received any training.

We found the home did have signage features that would help to orientate people living with varying degrees of dementia. We have made a recommendation about environments used by people with dementia.

During our inspection we checked to see how people's nutritional needs were met. People were allowed to eat at their own pace. The food looked appetising and most of the people finished their meal. In the nursing unit, we found a high number of people who used the service required assistance to eat their meal. This was completed

in a controlled and calm manner with staff interacting with questions such as 'are you enjoying your food' or 'is your food too hot'. Lunchtime was pleasant experience for people who used the service.

People and relative told us they or their loved one were well cared for at the home. One person who used the service told us; "The carers are lovely. If I call them using the call thing, they come straight away." Another person who used the service said "They are all lovely they look after us very well even when they are under pressure they are always polite."

Throughout the inspection we observed staff providing treatment and care in a kind and sensitive manner. People told us that care staff were polite, respectful and protected their privacy. A member of staff was chosen each day to be the service dignity champion and was expected to be the eyes and ears of each unit, observing practice and noting any disrespectful behaviour. They ensured that the dignity of people was respected at all times.

People and relatives told us they were involved in making decisions about their care and were listened to by the service. They told us they had been involved in determining the care they needed and had been consulted and involved when reviews of care had taken place.

On the whole most people we spoke with said the home was very responsive to their needs. However, one person and their relative told us that they were not wholly happy with the care provided and felt their relatives needs were not being met.

We found bedrooms were small and bright with beds suitable for the different needs of the residents. We noticed a lack of seating in the bedrooms for visitors, forcing relatives and visitors to sit on the bed.

During our inspection we noted 10 people in the nursing unit remained in their beds during the late morning. We found that care plans for five of these people had documented reasons why the people were still in their beds. For the remaining five people, care plans did not document any known reasons as to why they were being cared for in bed.

Summary of findings

'Flash meetings' were conducted by staff at the start of each shift, which acted as a handover and included any developments affecting people and was also an opportunity for management to share important information with staff.

The service employed two activity coordinators at the home. We looked at pictorial evidence of people enjoying themselves in the gardens and showing past events and celebrations. A theatre group and singers come to entertain on a regular basis and a Gospel choir was due to visit the home. We saw Union Jacks displayed in the entrance celebrating VE day.

The service sent out satisfaction surveys to people who used the service and their relatives as well as employees. We looked at minutes from a residents and relatives' meeting. Where concerns had been highlighted, these had been recorded on a notice board in the main reception area with the action taken by the service to address the issue.

All the people we spoke with on the day of our inspection knew who the manager was. They thought the new

manager had a very visible presence in the home and felt confident and happy to approach her with any concerns they may have had. Staff we spoke with told us they felt valued by management who were approachable and supportive.

The service undertook a comprehensive range of audits of the service to ensure different aspects of the service were meeting the required standards. However, we looked at a recent medication audit that identified missing photographs from medication records with no evidence of any action taken. In view of our findings around medication, which included the omission of some photographs, we questioned the effectiveness of these audits.

The service identified 'lessons learnt' from incidents, accidents, complaints and safeguarding. In response the service highlighted what it had learnt and what had changed as a result. This information was shared with staff through group supervision, staff meetings and daily 'flash meetings.'

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Not all aspects of the service were safe. We found that people were not protected against the risks associated with the safe use and management of medicines.

We checked to see how people who lived at the home were protected against abuse. We found people were protected against the risks of abuse because the home had a robust recruitment procedure.

On the day of our inspection, we found the atmosphere was calm and there were sufficient numbers of suitably qualified staff on duty to meet people's needs. On the whole, people we spoke with told us they thought that there was enough staff on duty throughout the day to meet their needs, but raised concerns about nights and weekends.

Requires Improvement



Is the service effective?

Not all aspects of the service were effective. We looked at training records and found that less than half of staff at the home had completed their annual e-learning in relation to safeguarding and less for the Mental Capacity Act (MCA). Training records also demonstrated that a number of staff were overdue training in a number of key training areas.

We looked at supervision and annual appraisal records and spoke to staff about the supervision they received. We found that not all staff received regular supervision.

We saw there were procedures in place to guide staff on when a Deprivation of Liberty Safeguards (DoLS) application should be made. However, some staff demonstrated a very minimal understanding around the principles of MCA with regards to DoLS and reported that they had not received any training.

Requires Improvement



Is the service caring?

The service was caring. People and relative told us they or their loved ones were well cared for at the home.

Throughout the inspection we observed staffing providing treatment and care in a kind and sensitive manner. People told us that care staff were polite, respectful and protected their privacy.

A member of staff was chosen each day to be the service dignity champion and was expected to be the eyes and ears of each unit, observing practice and noting any disrespectful behaviour. They ensured that the dignity of people was respected at all times.

Good



Summary of findings

Is the service responsive?

Not all aspects of the service were responsive. On the whole most people we spoke with said the home was very responsive to their needs.

During our inspection we noted 10 people in the nursing unit remained in their beds during the late morning. We found that care plans for five of these people had documented reasons why the people were still in their beds. For the remaining five people, care plans did not document any known reasons as to why they were being cared for in bed.

The service employed two activity coordinators at the home. We looked at pictorial evidence of people enjoying themselves in the gardens and showing past events and celebrations.

Requires Improvement



Is the service well-led?

Not all aspects of the service were well-led. We witnessed the manager supporting staff undertaking their work and helped with serving meals and supporting people during lunch time.

Staff we spoke with told us they felt valued by management who were approachable and supportive.

The service undertook a comprehensive range of audits of the service to ensure different aspects of the service were meeting the required standards. However, we looked at a recent medication audit and found it to be ineffective.

Requires Improvement



Kenyon Lodge

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 checked 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 unannounced inspection took place on 19 and 20 May 2015. The inspection was carried out by one adult social care inspector, a Specialist Advisor in nursing and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We also reviewed all the information we held about the home. We reviewed statutory notifications and safeguarding referrals. We also liaised with external professionals including the local authority safeguarding team, Clinical Commissioning Group and infection control team. We reviewed previous inspection reports and other information we held about the service.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

At the time of our inspection there were 50 people who were living at the home. There were 24 people who were living on the nursing unit situated on the ground floor and 26 people living on the residential unit, located on the first floor. We spoke with 10 people who lived at the home, 9 visiting relatives and two visiting health care professionals. We also spoke with two nurses, 12 members of care staff and the chef. We also spoke to the home manager and the regional manager.

Throughout the two days, we observed care and treatment being delivered in communal areas that included lounges and dining areas. We also looked at the kitchen, bathrooms and laundry rooms. We looked at the personal care and treatment records of people who used the service, staff supervision and training records, medication records and the quality assurance audits that were undertaken by the service.

Is the service safe?

Our findings

Without exception, every person we spoke with told us they either felt safe or believed their family member was safe living at Kenyon lodge. One person who used the service told us; “I feel safe living here. No concerns at all.” Another person who used the service said “I’m quite happy and I do feel safe. The staff are lovely and look after me.” One visiting relative told us; “I do have peace of mind, I know it’s safe.” Another visitor told us; “Never had any concerns, some residents are very demanding but the staff are patient and kind.”

Other comments included; “I feel dead safe here. Very happy, these girls are belting, kind and considerate. We always have a laugh and a joke.” “I feel my X is safe living here.” “I am in a safe place and a safe environment. There is always people about I can call on if feel ill.” “I feel very safe here I can hear the staff going about their jobs chatting to the other residents and laughing.” One visiting health care professional told us that they had no concerns about peoples’ safety since they started coming to the home.

A number of staff we spoke with told us they believed people were safe living at Kenyon Lodge and they would have no reservations about their own family staying at the home. Comments included; “I do think people are safe here and my own family have stayed here with no problems.” “I think people are safe and I would have my own family here.” “I feel people are safe staying here, if they weren’t I would soon tell the manager.” “My relative is here and it’s amazing how they have come on since coming here. My family are really impressed with the difference in my X.” “Safety is the main thing here, ensuring people are safe.”

As part of this inspection we checked to see how the service managed medication safely. We found the service had not protected people against the risks associated with safe management of medicines, because the provider did not have appropriate arrangements in place.

We looked at what arrangements were in place for storing and administering people's medicines. We found all medicines were stored securely in trolleys, which were kept in a locked treatment rooms when not in use in each unit. We found medicines were only administered by registered

nurses and trained care staff who had provided specimen signatures for auditing purposes. Staff had received training and their skills had been assessed by the service, which were verified from looking at training records.

The service mainly used a 'blister pack' dose system for the people who used the service to store their medication. Blister pack is a term for pre-formed plastic packaging that contains prescribed medicines and is sealed by the pharmacist before delivering to the persons care home. The pack had a peel off plastic lid and lists the contents and the time the medication should be administered.

Medicines that required refrigeration were stored in a medicines fridge as per manufacturers recommendations, located in the treatment rooms. Daily temperatures were recorded in line with guidance. We found there was a medicines policy in place, which included guidance on roles and responsibilities, administration and disposal.

Records supporting and evidencing the safe administration of medicines were not always completed. We looked at a sample of 14 medication administration record (MAR) charts. We found that photographs were not always in place to ensure medicines were administered to the right people. The MAR sheets for people who resided in the Nursing Unit were reviewed and signatures omissions were found in seven records. This meant we could not be certain that medicines were administered in line with their prescription. The service subsequently confirmed that medicines had been administered by staff, but signature entries had not been completed by staff.

From examination of records we found evidence of topical cream recording charts for people who used the service were in place and were kept in people’s rooms. However, instructions provided on the MAR by the pharmacist were not always accurately duplicated to the records maintained in people’s bedrooms. For example, in one instance pharmacist instructions clearly stated that ‘cream should be applied when required,’ while the instructions in the bedroom stated ‘apply after each wash.’ We found examples where pharmacist instructions clearly stated that creams should be applied ‘twice a day’, however records indicated that only one or no applications had taken place. This meant people had not received their medication in line with their prescription.

Is the service safe?

We found examples of where creams had been prescribed to people, however we found no records to indicate that the creams had been administered. This meant it was not possible to tell if a course of treatment had been administered correctly.

When checking medication trolleys, we found two examples of eye drops that had been opened, where the manufacture's instruction clearly stated that the medicine should be discarded after 28 days. No date of opening had been recorded on the package to ensure staff could follow the manufacturer's instructions safely.

We found instances where medicines recorded on MAR sheets had not been administered without any explanation for the omission. We asked the home manager to investigate these issues. We were subsequently told that the medicines had been stopped some months previously. The medicines had not been removed from the MAR and the service had not contacted the pharmacist to highlight the error. This meant records did not accurately reflect a person's medication requirements.

The cupboard that stored the End of Life medicines (EoL) was packed to capacity. However, medicines that were not required to be stored under controlled drug requirements were also found to be stored in the cupboard. On completing a stock control of the controlled drugs we found that a person had two supplies of exactly the same medicine, which were documented in two different areas of the Controlled Drugs Register. This double entry had the potential to cause the person harm as the drug count would depend on the stock balance that staff used at the time.

We found the EoL controlled drug stock control to be poor and did not comply with the service's procedure that was outlined on the daily handover sheet. The requirement was that the EoL/Controlled Drugs were to be stock checked each Monday. However, we found that EoL/Controlled Drugs stock control had not been completed since 19th February 2015. This demonstrated that the service had not completed an EoL/Controlled Drug check for 12 weeks in contradiction of service procedure of a weekly requirement.

We found that the registered person had not protected people against the risk of associated with the safe

management of medicines. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in regards to safe care and treatment.

We checked to see how people who lived at the home were protected against abuse. We found people were protected against the risks of abuse, because the home had a robust recruitment procedure. We reviewed a sample of 10 recruitment records, which demonstrated that staff had been safely and effectively recruited. Appropriate criminal records bureau (CRB) disclosures or Disclosure and Barring Service (DBS) checks had been undertaken and suitable references obtained.

We looked at whistleblowing instruction kept within the manager's office, which contained the contact details of the manager, the regional manager, social services, clinical commissioning group and CQC. Staff were encouraged to report any concerns they had regarding poor practice or abuse. One member of staff told about their own experiences, where they had reported concerns in the past regarding the inappropriate behaviour of a colleague and how they would not hesitate to report any concerns. One staff member told us; "If I had any safeguarding concerns I would speak to the manager, regional office, social services, Police and even CQC depending on the circumstances. I'm confident that any safeguarding concerns would be handled thoroughly by the manager." However, some staff we spoke with had limited knowledge regarding the principles and aims of safeguarding vulnerable adults.

We looked at a sample of nine care files to understand how the service managed risk. We found the service undertook a comprehensive range of risk assessments to ensure people remained safe. They included such area as cognitive assessments, falls, nutrition, manual handling, oral and continence. These provided detailed guidance to staff as to what action to take to ensure people remained safe and were regularly reviewed by the service. Each file contained a personal evacuation plan for the person who used the service, which contained guidance on arrangements in the event of an evacuation.

We looked at how the service ensured there were sufficient numbers of staff on duty to meet people's needs and keep them safe. We looked at staffing rotas and a dependency tool used by the service to determine staffing levels. On the day of our inspection, we found the atmosphere was calm

Is the service safe?

and there were sufficient numbers of suitably qualified staff on duty to meet people's needs. On the whole, people we spoke with told us they thought that there was enough staff on duty throughout the day to meet their needs, but raised concerns about nights and weekends. A relative told us they thought two staff on at night was not enough to deal with all the residents as some of the residents had very complex needs. One person who used the service told us; "Bit short at the weekend not as many staff. I don't need them at night I just get my head down and I am gone." Other comments included; "My view is that there is not enough care staff."

Staff told us they had no major concerns about staffing levels and that they found management responsive to any staffing issues. Comments from staff included; "Staffing levels are generally fine, but levels will need to be increased if we have more people staying." "I feel we do need more care staff in the nursing unit, one more carer as dependency needs for nursing are high. The matter has already been raised with the manager and they do listen to us." "I think the staff levels need slight adjusting at nights." "Night time is ok apart from the morning, but the manager is introducing a 6am – 12pm to provide additional support in the morning." "One nurse is enough at nights, but more staff are required in the morning, that's when we need more care staff."

The building appeared to be very clean and presentable, with visible canisters of hand cleansing gel located throughout the home. It was noticed that staff frequently used the gel on entering and leaving people's rooms. However, a hairbrush identified for communal use was found in a bathroom. A staff member reported that this was

used to tidy people's hair once they have had an assisted bath. We also found that liquid toiletries were left in communal bathrooms and a disposable razor with no blade cap in place left on the shelf in another bathroom. These items had the potential to cause harm and/or injury if digested/taken by a person/s who lived at the home.

A room located on the main corridor had an A4 piece of paper taped to it advising 'Oxygen Store Room'. A person whose room was located on the main corridor had a sign 'Oxygen in Use'. This was found to contravene the Health and Safety requirements as the service not displaying signs of 'No Smoking', 'Flammable Gas' and 'No Naked Flames'. Due to the potential seriousness of this, the Manager was immediately informed and took immediate action to address this concern.

We observed a push button key pad fitted to the main entrance door. We saw the key pad had the number required to release the door stuck to the key pad itself, which enabled people to leave the building. This led directly out on to a main roadway. We spoke to the home manager about the risk this presented for vulnerable people living at the home. The manager immediately addressed this concern by removing the number.

We were told that people did not have a key to their room or a locked drawer for their private belongings and raised concerns about other people wandering into their room. We spoke to the manager who told us they would ensure all new admissions were asked if they would like a key for their room if they had capacity. They were also in the process of asking all current residents that had capacity if they would like a key for their room.

Is the service effective?

Our findings

We looked at the training staff received to ensure they were fully supported and qualified to undertake their roles. People who lived at the home and their relatives told us they thought staff were trained to be able to meet their or their family member's needs. One person who used the service said "They seem to know what they are doing I think they do get trained."

We also checked to ensure that nurse's professional registrations with the Nursing and Midwifery council was current, which we confirmed from reviewing training records. Most staff reported that they had completed a three day induction and received an induction workbook. One member of staff told us; "My induction involved a three days shadowing senior staff e-learning, practical moving and handling." Another member of staff said "I had a really good induction, I followed a senior for three days, had training in manual handling, infection control, safeguarding and Deprivation of Liberty Safeguards (DoLS)." However, some staff reported that they were only shown around the building on their first day of their induction.

We were also told that staff had received training in safeguarding from the local safeguarding team and that medication workshops had been undertaken by a pharmacist. Percutaneous Endoscopic Gastrostomy (peg) care and training had also been delivered by an external source, which we verified from looking at training certificates. The service used a competency checklist on all nurses, which included peg feeding, infection wound care and catheterisation. The manager told us they were currently devising one for all care staff.

Staff told us that they received annual mandatory e-learning training which they found very useful and were encouraged in their own professional development such as undertaking National Vocational Qualifications (NVQ) in care. The manager told us that all care staff had either commenced NVQ training or had been enrolled of future courses. One member of staff told us; "I'm currently doing level two NVQ in social care and my assessor visits me often to review my work and any issues." Another member of staff said "We have e-learning, which we have to review every year and includes fire safety, safeguarding, DoLS and infection control. One member of staff is manual handling trainer, which is also refreshed every year."

However, some staff demonstrated a very minimal understanding around the principles of safeguarding vulnerable adults and Mental Capacity Act (MCA) with regards to DoLS and reported that they had not received any training around these subjects. We looked at training records and found that less than half of staff at the home had completed their annual e-learning in relation to safeguarding and less for MCA. Training records also demonstrated that a number of staff were overdue training in a number of key training areas including fire awareness, manual handling and infection control. One member of staff said "We have to do training in own time, but I've been here twelve months and have not received any manual handling training. I don't feel I'm getting much personal development."

We looked at supervision and annual appraisal records and spoke to staff about the supervision they received. We found that not all staff were receiving regular supervision. Supervisions and appraisals enabled managers to assess the development needs of their staff and to address training and personal needs in a timely manner. One member of staff told us; "I don't have regular supervision, I think it's because we are short of a deputy manager." Another member of staff said "I have not received any recent supervision." Other comments included; "We do have supervision, but I have not had one recently."

We found that limited supervision had taken place recently. We looked at the service supervision policy, which dictated that staff supervision should take place six times a year. We found no evidence supporting the requirements of this policy.

We found that the registered person had not ensured all staff received appropriate professional development and supervision. This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to staffing.

The Care Quality Commission has a duty to monitor activity under the Deprivation of Liberty Safeguards (DoLS). The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. We saw there were procedures in place to

Is the service effective?

guide staff on when a DoLS application should be made. We spoke to the manager, who was able to demonstrate that the service had submitted a number of applications in line with guidance from the local authority.

We observed that staff applied a very caring and sensitive approach when addressing people who used the service. They were polite and explained the reason why they had approached them, such as the care required. One person who used the service told us; “They always ask my permission to do things and are very polite.” However, not all staff we witnessed sought consent prior to a procedure or care event occurring.

We asked staff how they would ensure people with communication difficulties would provide consent in relation to individual care tasks. One member of staff told us; “With consent I would explain what I needed to do. I would know from their reaction if they didn’t want me to do it, which I respect always.” Another member of staff said “Lots of residents communicate in different ways and you get to know them. You quickly learn their body language. We also use picture cards to help people make choices around eating, bathing and dressing.”

We found the building was designed to meet the need of people living with mental health issues such as dementia. Corridors were straight and wide to aid visibility and accessibility. Hand rails were fitted to the walls. Signage on the doors of toilets and bathrooms were large and pictorial. Bedrooms had different coloured doors and displayed the picture and name of the occupant, however the names of the occupants were very small and in some cases missing. We did not see any evidence of dementia friendly resources or adaptations of corridors or communal areas.

We recommend that the service explores the relevant guidance on how to make environments used by people with dementia more ‘dementia friendly’.

During our inspection we checked to see how people’s nutritional needs were met. In the residential unit, we found tables were set with a tablecloth napkins cups, saucers, plastic beaker for water and a full set of condiments. We saw two sizes of plates, a smaller plate for people who could feel over faced by a large plate of food. People were allowed to eat at their own pace. The food looked appetising and most of the people finished their meal. In the nursing unit, we found a high number of people who used the service required assistance to eat

their meal. This was completed in a controlled and calm manner with staff interacting with questions such as ‘are you enjoying your food’ or ‘is your food too hot’. Lunchtime was pleasant experience for people who used the service.

One person who used the service commented ‘The food is lovely. It’s always nicely presented’. Other comments included; “Food is great, it’s what I like.” “Food is smashing, spot on. Never had any complaints.” However, some people we spoke with were not entirely happy with the food provided. One person said. “It’s a lot of mince based dishes. We do get a roast dinner on Sunday. Tea is always soup and sandwiches its boring.” Other comments included; “The food is awful here. Apart from the food I’m happy here.” “Food is really good some days and not so good on other days. Food is usually ok.”

We saw that drinks were available through the day. Jugs of water and juice were available in people’s rooms. On the residential floor we saw a water cooler for the use of the people who used the service, however no cups were available.

We saw that people did not have an opportunity to look at a menu and it was unclear whether people were given a choice, especially those who were in bed. Meal choices were listed on a small notice board in the dining room. We spoke to the chef who told us that people were asked what they wanted to eat and were offered a choice of meals. If people were unhappy with choices available, they could always have something else. We were shown minutes from a residents and relatives meeting in April 2014, where meal choices were discussed. The manager told us that they intended to undertake a food survey every three months in order to respond to people’s likes and needs. One member of staff said “I know the residents as individuals and know their needs. At lunch time people will sometimes ask for things and I know they actually prefer something else. So I always give them a choice and have another plate ready with what they like just in case.”

We looked to see how the service supported people with their on-going health support. We found the service recorded each person weight monthly within their care plan. The service also operated a ‘Weight Loss Diary’ were patients who had encountered weight loss during the preceding month were referred to the community dietician.

Is the service effective?

People told us that they were supported with hospital appointments and health care needs. One relative told us; “I’ve been very impressed how the home has chased up a referral that was made for my X.”

A GP attended the home every week or when required. We saw that the home worked closely with other professionals and agencies in order to meet people’s support

requirements. We saw a notice advising that the chiropodist would be visiting the home on a particular date. A visiting health care professional told us staff would approach them directly about issues during visits and were very pro-active with patients. They thought the staff were great.

Is the service caring?

Our findings

People and relative told us they or their loved one were well cared for at the home. One person who used the service told us; “The carers are lovely. If I call them using the call thing, they come straight away.” Another person who used the service said “They are all lovely they look after us very well even when they are under pressure they are always polite.” Other comments from people who used the service included; “The staff are very kind and very willing.” “Yes they are very kind they will do anything for you.”

One visiting relative told us; “Staff are friendly and welcoming, no concerns at all.” Another relative said “Staff are very friendly and helpful.” Other comments include; “Staff are very caring and we are made to feel welcome.” “Staff are very caring and lovely. I think the place is lovely. We come unannounced and are very impressed. No smell it’s lovely.”

Throughout the inspection we observed staffing providing treatment and care in a kind and sensitive manner. We saw one member of care staff encouraging a person who used the service to walk from the dining room back to the lounge with the aid of a walking frame. The person was sure they were unable to complete the journey, but with a lot of encouragement and support from the member of staff, they made it and were very proud of themselves. We saw people who wanted to mobilise independently being able to do so.

People told us that care staff were polite, respectful and protected their privacy. One person said. “They always knock on my door before coming in and close my curtains while I am getting undressed. When I have a bath they always ask me if they can wash me. They always find a nice big fluffy towel to wrap me in.” One relative said. “The staff are very kind, some are better than others I come here every day they all know me and I have a laugh with them all.”

We looked at a ‘dignity board’ in the reception of the home with dignity ‘do’s and don’ts’. A member of staff was chosen

each day to be the service dignity champion and was expected to be the eyes and ears of each unit, observing practice and noting any disrespectful behaviour. They ensured that the dignity of people was respected at all times. The manager told us their dignity champion acts as a role model and would challenge any disrespectful behaviour.

People and relatives told us they were involved in making decisions about their care and were listened to by the service. They told us they had been involved in determining the care they needed and had been consulted and involved when reviews of care had taken place. One person who used the service told us; “They always speak to me and involve me in my changing needs.” Another relative said “We have been involved in assessments and mentioned concerns, which have been addressed. We find the home is open and honest.” We looked at a ‘service user/ relative care planning involvement form’, which was contained in each care file. This demonstrated that people had been consulted and involved in their care needs, which was signed by the person who used the service or their representative.

The manager told us that the ‘End of Life’ (EoL) care provided by the service was currently under review following a recent safeguarding incident. At present, the local District Nursing Service was supporting the management of EoL Care within the home so that people could have comfortable, dignified and pain free death. The manager further reported that the return of EoL care management would be returned to the home using a phased approach to ensure that the service was delivered safely and appropriately by the nurses employed by the service. The manager told us that the district nurse support with EoL Care was an informal agreement. However, the manager was advised that a formal agreement of district nurse response times was needed in order to protect people in terms of achieving comfort in a timely and acceptable manner.

Is the service responsive?

Our findings

On the whole most people we spoke with said the home was very responsive to their needs. People told us that staff immediately responded to any call bells going off. One person who used the service said “When I ring my call bell they are excellent at answering it.” A visiting health care professional told us that staff were very responsive, they undertook blood sugar levels, which were always done and recorded.

However, one person and their relative told us that they were not wholly happy with the care provided and felt their relatives needs were not being met. Because the person who used the service had difficulty communicating their needs they felt the staff had a lack of understanding of their specific needs. This had resulted in a number of concerns. They also told us that management appeared to listen to what they had to say, they either did nothing or it took a long time for the concern to filter down to the staff and get implemented. We spoke to the manager about these issues who was fully aware of the concerns raised and ensured us they would meet with the family to resolve these matters.

People we spoke with told us their thought that their pastoral needs were met. One person who used the service told us they had “tea with the vicar” on Sunday afternoons. They also said “It is a lovely service X comes in and gives us Holly Communion and we sing hymns.”

We found bedrooms were small and bright with beds suitable for the different needs of the residents. Some rooms had been personalised with beds, duvet covers and curtains all matching, which relatives had bought in for their loved ones. We noticed a lack of seating in the bedrooms for visitors, forcing relatives and visitors to sit of the bed. We spoke to the manager about suitable seating for families who agreed to address the issue.

We looked at a sample of nine care management files. All care plans provided instructions to staff on the level of treatment and care required for each person. These were all found to be of a good standard in terms of presentation. They were sequential and indexed and easy to follow. Each care management plan included care plans for individual care needs, which included personal hygiene, nutrition, mobility, medication, sleeping, continence and skin care. Each care plan was reviewed each month. The reviews were very brief and non-informative in terms of effectiveness of

prescribed care being delivered. The reviews mainly consisted of a one line repetitive statement e.g. continues with current care plan. We looked at post falls observation records, which detailed observation immediately undertaken after a person had fallen to ensure there were no complications that required further attention.

During our inspection we noted 10 people in the nursing unit remained in their beds during the late morning. We found that care plans for five of these people had documented reasons why the people were still in their beds. For the remaining five people, care plans did not document any known reasons as to why they being cared for in bed. These 10 people were at risk of being socially isolated. However, we were told by staff that the service activity coordinator would provide one to one activity sessions to these people, which was also not documented in the care plan.

The service operated a key worker role, where each person had a nominated and agreed member of staff who had specific responsibility for meeting their needs. This included; understanding the day-to-day needs of the service user; promoting social activities and community involvement; building trusting relationships and respecting religious beliefs and spiritual needs.

‘Flash meeting’ where conducted by staff at the start of each shift, which acted as a handover and included any developments affecting people and was also an opportunity for management to share important information with staff.

The service employed two activity coordinators at the home. We looked at pictorial evidence of people enjoying themselves in the gardens and showing past events and celebrations. None of the photographs were dated. People told us they could involve themselves in activities if they wanted. One person who used the service said; “We have games, bingo with the activities lady, they do enough for me.” Another person who used the service told us; “With activities, I prefer being on my own reading or watching telly. I will go and watch the singers that come in or bingo.” Other comments included; “They are very good at organising things, they took me to watch the rugby.”

We saw notices on the notice board announcing an invitation to join in the Whit Walks. A theatre group and singers come to entertain on a regular basis also a Gospel choir was due to visit the home. We saw Union Jacks

Is the service responsive?

displayed in the entrance celebrating VE day. We looked at a four weekly activities program that listed activities such as; Bingo, cheese and wine afternoons, craftwork, games, flower arranging and gardening. Most of the activities could be enjoyed by the more able residents. We spoke to the two activities coordinators who told us that in addition to organised events, they took people shopping or out to lunch individually or as a group. They also engaged with people who were less able on a one to one basis, which included memory books and recorded the engagement in people's daily records.

We found the service did listen to people's concerns and experiences about the service. The provider had effective systems in place to record, respond to and investigate any complaints made about the service. The service sent out satisfaction surveys to people who used the service and their relatives as well as employees. We looked at minutes from a residents and relatives' meeting. Where concerns had been highlighted, these had been recorded on a notice board in the main reception area with the action taken by the service to address the issue. Also available in the reception was a 'suggestion box' for people to use.

Is the service well-led?

Our findings

There was no registered manager in place at the time of our inspection. However, a new manager had been appointed who had previously worked as the deputy manager at the home and was very knowledgeable about all aspects of the service. They were currently applying to register with CQC as the registered manager for the service. 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 new manager was present throughout our inspection and was very responsive to any the feedback we provided. We witnessed the manager supporting staff undertaking their work and helped with serving meals and supporting people during lunch time. We observed the manager interacting with people who used the service in a friendly and personalised manner, it was apparent the manager knew the names of people and was able to speak in some detail about them.

All the people we spoke with on the day of our inspection knew who the manager was. They thought the new manager had a very visible presence in the home and felt confident and happy to approach her with any concerns they may had. One relative told us; "Any issues I would speak to staff or the manager, that includes complaints, but I have never had cause to complain." However some relatives thought that the manager could be more proactive in following up concerns they had about their loved ones by ensuring that staff followed through their wishes.

Staff we spoke with told us they felt valued by management who were approachable and supportive. One member of staff said; "The culture here is very friendly, very approachable. The manager is lovely. I have confidence to approach her about issues, her office door is always open." Another member of staff told us; "The manager encourages us to be open and honest and I wouldn't hesitate speaking about anything. We do feel appreciated, management are pleased with us and do show it. They always listen to any

issues or suggestion we have." Other comments from members of staff included; "I feel really good working here, the manager is doing well. I would go straight to her with any problems. All the changes she is making are for the better." "There is an open and honest culture and we are encouraged to speak out." "There is a good atmosphere here and it is a good place to work, everyone is very supported, but it hasn't always been like this." "The manager makes me feel valued."

The service undertook a comprehensive range of audits of the service to ensure different aspects of the service were meeting the required standards. These included monthly audits of care files, weekly weight monitoring, wound audits and infection audits. We looked at a quality dining audit carried out by staff that included dining experience, choices and environment. We looked at remedial action plans to address any concerns identified. However, we looked at a recent medication audit that identified missing photographs from medication records with no evidence of any action taken. In view of the additional concerns we found around medication, we questioned the effectiveness of these audits.

Daily safety checks were undertaken in respect of fire exits, heating and call bells. Weekly checks of the fire alarm, pressure mattresses and bed rails were undertaken. Window restrictors were checked monthly. Fire risk assessments had been undertaken with gas and electric installations subject of current inspection certificates.

The service identified 'lesson learnt' from incidents, accidents, complaints and safeguarding. In response the service highlighted what it had learnt and what had changed as a result. This information was shared with staff through group supervision, staff meetings and daily 'flash meetings.'

We found that accident and incidents were correctly recorded with corresponding entries made in individual care files detailing any action taken.

Providers are required by law to notify CQC of certain events in the service such as serious injuries and deaths. Records we looked at confirmed that CQC had received all the required notifications in a timely way from the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity

Regulation

Accommodation for persons who require nursing or personal care

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

We found that the registered person had not protected people against the risk of associated with the safe management of medicines.

Regulated activity

Regulation

Accommodation for persons who require nursing or personal care

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 18 HSCA (RA) Regulations 2014 Staffing

The registered person had not ensured all staff received appropriate professional development and supervision.