S J Pittman Limited

Lodore Nursing Home

Inspection report

9 Mayfield Road
Sutton
Surrey
SM2 5DU

Tel: 02086423088

Date of inspection visit:
09 May 2017

Date of publication:
07 June 2017

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 9 May 2017 and was unannounced. At our last comprehensive inspection in January 2015 we rated this service 'Good' as we found they were meeting all legal requirements.

Lodore Nursing Home provides accommodation with nursing and personal care for up to 36 people. This includes palliative and end-of-life care. At the time of our inspection there were 29 people using the service.

The service was required to have a registered manager in post but did not have one at the time we carried out this inspection. A manager had been in post since November 2016 and was undergoing the process of registration with the Care Quality Commission.. 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.

There were a range of checks and audits to monitor the quality of the service. However, one of these audits had not identified an anomaly with medicines' recording which we found during this inspection. The manager took prompt action to address the anomaly. Notwithstanding the issue above, people received their medicines as prescribed.

The provider gathered information prior to people being admitted into the home to help ensure they were able to meet people's needs. Care plans were developed which were specific to each person and described how the person wished to be cared for.

People were encouraged to make choices for themselves whenever possible this included, being able to choose if they wanted to participate in activities. Where people did not want to take part in group activities, there were opportunities for staff to engage on a one to one level with for people.

There were measures in place to help ensure only suitable people were employed by the service. Staff received training which was refreshed regularly so they were up-to-date with the relevant training. Enough staff were deployed to effectively meet people's needs.

People had support to access appropriate healthcare and their nutritional needs were met according to their needs and preferences. The provider was able to offer appropriate end of life care to people.

The provider worked within the remit of the Mental Capacity Act 2005 (MCA). Staff were aware and knowledgeable about the MCA and how it impacted on people who used the service. Staff sought consent from people prior to providing care. Staff generally treated people with dignity and respect.

There were assessments in place which identified possible risks to people and others and action that needed to be taken to minimise the risks. These included measures to prevent the risk of infection and to

help ensure people were protected from possible harm and the measures they needed to take if they were concerned about someone's welfare.

There were a number of ways people could comment on the quality of the service. There were annual postal surveys and resident and relatives meetings. People knew how to make a complaint if they were unhappy with the service and told us they felt able to approach the manager or operations director with their concerns.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Staffing levels were sufficient to meet people's needs. People received their medicines as prescribed.

There were safeguards in place to help keep people safe from abuse. This included checks on staff to make sure they were suitable prior to employment.

There were assessments of possible risks to people and how these could be mitigated.

Is the service effective?

Good

The service was effective. The provider ensured staff were sufficiently trained to undertake their roles and responsibilities.

Staff understood the implications of the Mental Capacity Act 2005 and how it may impact on people. Staff sought consent from people prior to providing care to them.

People had access to healthcare services they needed. Their nutritional needs were also met.

Is the service caring?

Good

The service was caring. Staff in general, treated people with dignity and respect.

People were able to maintain contact with friends and relatives.

The provider was able to offer end of life care to people, as their staff were trained and they had links with appropriate healthcare professionals.

Is the service responsive?

Good

The service was responsive. Prior to coming into the home, people's needs were assessed.

Care plans detailed preferences of how people wanted their care to be delivered. People were offered a range of activities to ensure they were engaged and stimulated according to their

likes and dislikes.

There were procedures in place to deal with people's concerns and complaints.

Is the service well-led?

Good

The service was well-led. There were a range of audits and checks to monitor the quality but one these checks had not identified an issue we found in relation to medicines. The manager addressed the medicines issue as soon as we pointed this to them.

The provider used a variety of methods to continually seek feedback from people about the service. These included meetings with people and their relatives and satisfaction surveys.

People told us the manager was approachable and staff told us they were able to express their views about the service and these were taken seriously by the provider.

Lodore Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 9 May 2017 and was unannounced. It was carried out by an inspector.

Prior to the inspection we reviewed information we had received about the service such as notifications they are required to submit to CQC. Notifications contain information about significant events the service is required to inform us about. We also looked at previous inspection reports.

During the inspection we spoke with one person who used the service and four relatives who were visiting. As some people living at Lodore Nursing Home were either unwell or living with dementia, they were unable to fully share their views of the service with us. We therefore used our Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who cannot talk with us.

We also looked at information pertaining to five people who lived at the home; this included their care plans and medical information. We reviewed five staff files to check recruitment practices and information which related to the running of the home. We spoke with four members of staff, the manager and the provider's operations director.

After the inspection we had contact with a clinical nurse specialist, GP and the local authority quality assurance team.

Good

Is the service safe?

Our findings

People told us they felt Lodore Nursing Home offered a safe environment for them or their relatives. One person said, "Staff are very kind, I don't ever have to worry," and a relative told us, "I don't ever worry about leaving her [relative] here".

There were sufficient staff to meet people's needs. A relative told us, "Always seem to be enough staff, if I need someone I go and get them and I can always find someone pretty quickly," and another explained if they pressed the call bell then a member of staff responded promptly, this included at night. We saw during the day there were two registered nurses and seven carers across the three floors of the home. The manager told us they did not have any staff vacancies at present and if staff were unable to work due to sickness, the manager called on existing staff from one of the providers' two homes for cover. It was only if this was unsuccessful, the service approached an agency to provide staff cover; we were told by the manager that this was approximately twice a month. From our observations, staff were able to respond to people's requests promptly and were therefore able to meet their needs.

Staff knew how to keep people as safe as possible. The provider ensured staff received regular training to safeguard people at risk and there were policies and procedures which helped staff to know what action they should take if they suspected people were at risk from harm. We spoke with several staff who were able to describe the possible signs of abuse and what action they would take if they were concerned about anyone.

We saw the provider completed a number of pre-employment checks to help ensure only suitable staff were employed. From the records we saw there were application forms, proof of identity and address and criminal record checks. We saw the criminal records checks were renewed every three years in line with best practice, to make sure staff were still suitable to be employed. Where applicable, there was also information about people's right to work and nurses' professional registration details. We noted there were a small number of references which had been supplied by relatives and friends, who were unlikely to be impartial. We discussed this with the operations director, who said that in the first instance they always sought references from previous employers or impartial people in the community, such as priests or GP's. However, there were a small number of people who were unable to supply such references as they had recently come into the country. The operations director told us they had assured themselves of the person's suitability by undertaking other checks wherever possible.

People continued to receive their medicines as prescribed. Since the previous inspection, the provider had introduced the 'bio-dose' system as a way of administering medicines to people. The system allowed for a community pharmacist to dispense tablets and liquid medicines into dispensing pods, which were then administered in the home. There were additional safeguards to the system which included a description of each tablet or liquid to help ensure all medicines were correctly administered. We checked the Medicines Administration Records (MAR) and saw they had been completed with no omissions. There was also a photograph of each person within the service and information about how they preferred to take their medicines and if there were any known allergies. In this way the provider was ensuring the risk of errors was

minimised.

The home looked clean and was free from malodours. We saw there were domestic staff on duty in the morning. The bathrooms were equipped with soap, sanitisers and paper towels, and there were reminders about the importance of effective hand washing. The provider used colour coded bags to help identify waste so it could be disposed of appropriately. We saw staff had also completed food hygiene courses and that kitchen staff completed a range of checks when storing and preparing food. This included checking the temperatures of refrigerators and freezers, and checking the temperature of food as it was served to people.

Risks to people were managed effectively. We saw there were risks assessments in place for people, these included moving and handling, risk of falls and skin integrity. Each assessment was specific to the individual and highlighted the risk and what action was needed to minimise the risk. For example, a summary of what specific equipment was required for each person who needed assistance with moving was included in their moving and handling risk assessments. We saw these risk assessments were reviewed monthly and more regularly if it became necessary.

The provider maintained a log of all incidents and accidents that occurred within the home. This helped to identify any learning and to minimise the risks of reoccurrences. The manager was able to give us a recent example of someone who had two falls over the weekend. The service had provided the person with one to one support to help prevent further falls until such time they were able to refer the person onto the appropriate healthcare professional.

Good

Is the service effective?

Our findings

Staff were trained and supported to undertake their work effectively. The provider had identified 12 training courses which it considered mandatory, these included moving and handling, dementia awareness and food hygiene. Staff confirmed the level of training they received which had included an induction period when they had started in their roles. The provider maintained a training schedule which confirmed when particular training had been completed and when it was due for renewal. Specialist training for the registered nurses was also provided. A nurse told us about recent training they were supported to attend regarding the use of certain equipment such as syringe drivers; it had been provided by the Clinical Commissioning Group (CCG) and the nurses' competence in the use of syringe drivers was later tested. In this way the provider was ensuring their staff were up to date and knowledgeable about best practice in caring for people.

Staff were also supported in their roles. They were given an opportunity to meet formally with their line managers every three months. This gave staff an opportunity to discuss their professional development and any other issues regarding their work.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The provider had made a number of applications to the relevant authorities to deprive people of their liberty and these had been approved. We also saw staff had received training in MCA and DoLS and when we spoke with them, they were aware of who had restrictions on their liberty and how this may impact on them. In this way the provider was ensuring they worked appropriately within the remit of the legislation.

When people initially started using the service, we saw there was an assessment of their capacity to consent to their care If people were unable to consent then we saw the provider held meetings to make sure the care proposed was in the person's best interest. Irrespective of people's ability to give consent, people were still asked if they wanted care before it was provided. Staff gave us an example of someone not wanting to have a shower, and said they would respect the person's decision at that time but would come back to them at a later time to see if they had changed their mind.

People's nutritional needs were met. Kitchen staff told us they would spend time with each new person to

find out what they liked to eat and drink. They were also aware of people's dietary requirements such as those people who had difficulties with swallowing and therefore required a pureed or soft diet. We saw the provider had regular contact with healthcare professionals such as dietitians to ensure people's nutritional needs were reviewed if they had any concerns.

We saw the service supported people with their health needs. Staff used screening tools to help them assess if people had particular health conditions. For example, there was a mental health tool which helped to identify if people were at risk of becoming depressed. We saw the home also had weekly visits from their GP, who could also be contacted for more urgent visits. People had access to a range of other professionals which included a nurse specialist who told us the service worked well with them and was responsive.

Good

Is the service caring?

Our findings

Relatives told us staff were kind and caring. One said, "The love and care they receive here is the best, I'd give it top marks" and another said, "They're all so lovely here".

Staff knew how to maintain people's privacy and dignity. A relative told us, "They always look after her [relative] dignity, she's always covered up and looks nice." Staff were able to tell us what action they would take when providing personal care to make sure people had as much dignity as possible, this included closing doors and curtains, and talking to the person and telling them what they were doing during the process.

Notwithstanding the above we did observe interactions during our observations of care which showed that people might not have had the best lunchtime experience. Whilst staff were in the main kind and caring, we did observe them assisting people with their meal by standing over them, before moving onto their next task. One person eating their meal was also heard to say, "Why don't you sit down?" to a member of staff. Whilst the comment was acknowledged the staff member continued to stand waiting to start their next task. This meant people were being supported with their meals, but may have felt their dignity was compromised.

During our SOFI observations, the manager also came into the dining room and observed the interactions between people and staff. The manager was able to identify how the lunchtime experience could have been improved. By the end of the inspection he had already raised and discussed the issue with the staff members involved. We were therefore assured the manager would be able to address and rectify the issues raised.

People maintained relationships that were important to them. Throughout the inspection, the home was visited by a number of relatives. They told us there were no restrictions on them about when they visited and how they long they stayed. One relative said because of their work commitments she was only able to visit at particularly times of the day, another relative told us she visited every day and tended to stay for the whole day. All the relatives we spoke with commented on how friendly staff were "from the kitchen staff upwards", and how they were made to feel welcome.

The home was able to provide end of life care to people. Staff had received training from the clinical nurse specialist who told us the training was well attended and received by staff at Lodore. The nurse specialist was also able to offer more general support to the staff and visited regularly. We saw on some people's care plans that their wishes for end of life care was recorded, this included a 'Do not attempt resuscitation' form should they become unwell and stop breathing. We spoke with a number of relatives who were able to tell us how important it was for them to be able to visit the home as their family member was nearing the end of their life. They went on to tell us the home communicated well with them about their relative which was crucial for them, and that the home supported them effectively.

Good

Is the service responsive?

Our findings

The provider ensured they could meet people's needs prior to them being admitted to the home. Within people's care plans we saw a 'nursing admission form' had been completed and the provider gathered as much information as they could from other professionals and relatives. From this information the provider developed care plans which took account of people's personal support and health care needs.

Within the care plans there was important information for staff such as the person's life history which helped staff to better understand the person they were working with and prompted them with possible conversations topics. We saw care plans were signed by the individual or their representative as a way of indicating their agreement with the care that was being provided. We saw the care plans were reviewed monthly and more frequently if people's circumstances changed. In this way, the provider was ensuring they were meeting the personalised and current needs of people.

We saw staff encouraged people to make choices for themselves. For example, people were asked in the mornings what meal they would like at lunchtime, if however they changed their minds in the intervening period, this could be accommodated. We heard many other examples of staff promoting choice which included, "Do you think you might be better with a spoon or a fork?", "Can I help you with that?" and "Is it alright to move this forward?"

There were a range of activities on offer to people. The operations manager told us there was at least one activity on offer every day. This included sing along sessions, an entertainer, bingo and chair exercises, and for those who were unable or preferred to stay in their bedrooms, there was a volunteer who spent time with people on a one to one basis. On the day of the inspection, there was a sing along session in the morning and chair exercises in the afternoon. We were also told that Lodore supported people to meet their spiritual needs, so currently there were weekly visits from a priest and a volunteer who was able to give Holy Communion.

No one we spoke with had made a complaint and records showed the provider had not received a complaint about the service since our last inspection two years ago. One relative said, "He [relative] has been here four years and there has never been a problem." Although one relative told us, their mother's clothes went missing sometimes but they always turned up, and it had not been an issue for them. People did tell us if they had a complaint they would be able to raise it with staff or managers and felt their views would be listened to and action taken accordingly. The provider had a complaints procedure with a copy readily available in people's bedrooms and the communal areas. We noted however, that the complaints policy was inaccurate as it stated complaints could only be raised with the CQC. The policy did not make it clear the CQC cannot consider individual complaints, nor did it mention that people could seek readdress from the placing body, either the local authority or CCG. We discussed this with the operations manager who said they would review the policy to ensure the details were correct and to avoid possible delays in resolving complaints and confusion.

Good

Is the service well-led?

Our findings

The provider carried out a number of audits and checks regularly in order to monitor the quality of the service. For example, with regard to medicines, the manager told us they audited the storage, recording and handling of medicines every three months and a registered nurse audited on a weekly basis. We found no errors in medicines administration, although we did find an anomaly in the recording and management of a type of medicines, which had not been identified during the weekly audit.

The anomaly was regarding the recording of controlled drugs. Some prescription medicines are controlled under the Misuse of Drugs 2001, and there are specific arrangements for their storage, recording and administration. We found the running total of a controlled drug administered for one person was missing a dose, and for another person on the same medicine there was an additional dose. This anomaly had not been identified since the last audit three days previously. Whilst there were no indications that people did not receive their medicines as prescribed, there was a recording error that had not been identified by the audits. We discussed this with the manager who told us they would try to establish why the incident had occurred and how they could prevent any future reoccurrences. They also told us they would be completing additional checks in the interim until they could assure themselves the risk of repeat incidents were minimised.

Notwithstanding the above, we saw the manager undertook a range of other checks and audits to monitor the quality of the service. This included a check of four or five care plans per months to ensure all the information was up-to-date. This in particular focused on risk assessments and medical information. We saw there were also regular checks on the maintenance of the building and equipment used.

People we spoke with felt they could approach the manager or the operations director with any concerns or issues. One relative said of the manager, "He's very gentle" and another said, "He [manager] said they wouldn't give up on mum and we found that very reassuring". One relative did tell us they were disappointed the previous registered manager had left quite suddenly and only later was it explained why they had moved. Staff also told us they were positive about the new manager who they considered was open and listened to their views.

The manager was currently awaiting the outcome of their application to be registered with the CQC. The manager had previously been registered with another service and was aware of their roles and responsibilities. They were knowledgeable about their duty to notify CQC of incidents which may impact on the running of the service or particular individuals within the service.

The provider used a variety of ways to seek people's views about the service. We saw there were residents and relatives meetings and the last one was held in March 2017, when the new manager was introduced and there were discussions about possible summer activities. We were also shown the results of the last customer satisfaction survey which was completed in September 2016, which showed 94% of respondents, said the home was excellent or good.