Barchester Healthcare Homes Limited

Cheverton 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?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires improvement

Overall summary

Cheverton Lodge is a 52 bed nursing home which provides nursing and personal care for up to 46 older people and six young people with physical disabilities. Each person has their own bedroom and there are communal lounge and dining areas on each floor of the home.

This inspection took place on 14 and 16 April 2015 and was unannounced. At our last inspection in June and July 2014 the service was meeting the regulations we looked at.

At the time of our inspection a manager was employed at the service and had recently submitted the application to register with the 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 systems and processes in place to protect people from the risk of harm. These included appropriate staff recruitment processes, staff training, policies and systems to protect people from abuse. Staff were able to demonstrate knowledge of safeguarding and what they would do if a concern arose.

Summary of findings

We found there were the designated number of staff on each floor during our visits, however, they were often rushed and constantly engaged in care tasks and on occasion there were none in the communal areas at all. Staff were constantly required in people's rooms to carry out care tasks with little leeway for staff to be present in communal areas to identify and respond to immediate assistance that people required.

Risk assessments were in place in relation to falls and those associated with people's day to day care. The instructions for staff were detailed and clear. However, in one example a care plan said a person should be checked hourly as they were at risk of falling as they had refused to have a bed rail on their bed. Hourly checks were not being recorded.

We saw there were policies, procedures and information available in relation to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) to ensure that people who could not make decisions for themselves were protected. The service was applying MCA and DoLS safeguards appropriately and making the necessary applications for assessments when these were required.

People were supported to maintain good health. Nurses were on duty at the service 24 hours a day and a local GP visited the home each week, but would also attend if needed outside of these times. Staff told us they felt that healthcare needs were met effectively and we saw that staff supported people to make and attend medical appointments, for example at hospital.

Most of the people we spoke with who either used the service, and relatives, praised staff for their caring attitudes. The care plans we looked at were based on people's personal needs and wishes. Everyday things that were important to them were described so that staff could provide care tailored to meet their needs and wishes. Details were recorded of what people were able to do for themselves to enable them to maintain their independence. However, we found that not everyone's care records were being held securely and confidentially as we found two instances where care records were left accessible to people in a lounge and at a nursing station.

People's views were respected as was evident from conversations that we had with people using the service, relatives and staff. We saw that staff were involved in decisions and kept updated of changes in the service and were able to feedback their views and opinions through daily staff handover meetings.

The service complied with the provider's requirement to carry out regular audits of all aspects of the service. The provider carried out regular reviews of the service, sought people's feedback on how well the service performed, and outlined any the areas of improvement that were necessary to maintain the quality of the service.

At this inspection there were two breaches of regulations relating to regulations 10 and 18. You can see what action we told the provider to take at the back of the full version of the report.

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?

The service was usually safe. However we found that at times staff were not available to respond to care requests from people in communal areas of the home. People's safety and any risks to that were identified and reviewed. There was a lack of consistency among the staff team about how to respond to all potential risks, particularly in relation to the use of bed rails.

Staff were recruited safely with background checks being carried out and verified before staff were permitted to start working at the home.

Medicines were managed safely and the staff responsible for handling and administering medicines were suitable qualified and trained to do this.

Requires improvement

Is the service effective?

The service was usually effective. Staff received regular training, supervision and appraisal to ensure they had the skills and knowledge to meet the needs of people using the service. There was clear knowledge about how to assess and monitor people's capacity to make decisions about their own care and support, although people's care records were not always held securely.

People's healthcare needs were monitored and responded to appropriately and good health was promoted as well as the maintanence of a good diet and nutritional needs.

Good

Is the service caring?

The service was caring. Staff were seen speaking with people in a respectful and dignified way. Most of the staff team demonstrated a good knowledge of people's characters and personalities. We saw that when staff were providing assistance this was always explained, for example when moving somebody or assisting them with eating and drinking.

Good

Is the service responsive?

The service was responsive. We found that most people were actively engaged in daily activities although it was acknowledged that the lack of a driver for the minibus placed a limitation on people's opportunity to take trips outside of the home. The service showed us what steps they were taking to resolve this.

Complaints were managed effectively and the comments that people made people were listened to and matters they raised were responded to appropriately.

Good

Summary of findings

Is the service well-led?

The service was not always well-led. The provider had a system for monitoring the quality of care. Surveys were carried out on people using the service, relatives and others. These showed that most people were usually very satisfied with the service provided and, where this was not the case, the service took people's views seriously and took steps to make improvements.

Condidential information about people's care and support needs was not always held securely.

Requires improvement

Cheverton 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 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 was unannounced which meant the provider and staff did not know we were coming. The inspection took place on 14 and 16 April 2015. The inspection team comprised of two inspectors and an expert by experience who had specialist knowledge of caring for a person who used care services.

Before the inspection, we looked at notifications that we had received and communications with people, their relatives and other professionals, such as the local authority safeguarding and commissioning teams and the local specialist NHS trust nursing team.

During our inspection we also spoke with nine people using the service, four relatives who were visiting, six members of staff (four care staff and two nurses), the manager, the deputy manager and the area manager for the provider.

As part of this inspection we reviewed twelve people's care plans. We looked at the training, appraisal and supervision records for the staff team. We reviewed other records such as complaints information, quality monitoring, audit information, maintenance, safety and fire safety records.

Requires improvement

Is the service safe?

Our findings

All of the people we spoke with who lived at the home told us they felt safe. For example, they said "yes, everyone's nice to me", "I have no complaints." and "yes, very [safe]." One person said that their only concern was about falling but that would be because of their own "carelessness, and they come very quickly when you need them." Another person told us "sometimes you have to wait for the hoist but they do come eventually. They've been very busy this last couple of weeks because they're very short staffed at the moment." The issue about the availability of hoist we later found to be about the speed of staff response rather than a lack of equipment.

Some relatives also mentioned staffing and felt it had an impact on safety. One person told us their relative "doesn't feel safe at night, they sometimes take a long time to answer the call bell, there don't seem to be enough staff around." They went on to say that they thought there were a lot of people with significant medical needs and not enough staff to address those needs and added, "the nursing side seems to be quite stretched." Another relative echoed this view about staffing and waiting for the hoist. They also said sometimes there were only two care workers on duty on the first floor which they didn't feel was enough. This relative also commented on what she thought was a high turnover in staff. They said, "you don't see the same person twice."

Another relative had a different view and said, "it's small and friendly and I see the same people [staff] around when I come." However, a little earlier we saw this relative looking for a care worker to help but there were no care workers visible. At the same time, someone came of out their room and needed assistance. When a care worker was found they had to rush between the two, promising the second person they would return to help while running to stop someone else who was trying to get out of bed unaided from falling.

The absence of staff was observed further on several occasions, particularly on the first floor where there were substantial periods of time during which no care worker was present neither in the lounge nor within viewing or hearing distance of it. There were two call bells in the first floor lounge but neither were within people's reach. When one person wanted to go to the toilet, there was nobody around to ask for help. As they appeared to be becoming distressed, a member of the inspection team went in search of a care worker to assist them. There was nobody to be found in any of the public areas including the nurse's station nor visibly in the corridors. Care workers were all in bedrooms with the doors closed, assisting people. One had to stop what they were doing to go to the lounge to provide assistance there.

The new manager and the area manager both told us that they had honoured staff annual leave requests as the previous manager had not managed this correctly. We were told that the requests had been made some time ago and had not been passed on to provider's personnel department, being found only recently in paperwork at the home. The manager and area manager accepted that this had caused recent issues and had sent a memo to all staff outlining the accepted level of staff leave among each staff grade at any one time. We saw the memo to staff displayed in each nursing station to that effect.

Staff we spoke with consistently told us that over recent weeks there had been issues about staff levels at the home. We were told "Agency staff are used regularly at night time but don't do more than the basics and we have to catch up during the day." We found there were the designated number of staff on each floor during our visits, however, they were often rushed and constantly engaged in care tasks and on occasion there were none in the communal areas at all. Staffing levels at the home had remained unchanged since our previous inspection and dependency levels of each person were identified, but would be subject to change at the times of ill health. Two staff told us that there were busier times in these circumstances and at different times of the day, usually during the daytime. However, on the first day of our inspection we found that staff were constantly required in people's rooms to carry out care tasks with little leeway for staff to be present in communal areas to identify and respond to immediate assistance that people required. This posed a potential risk to people if staff were at times not able to respond. This was in breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had access to the organisational policy and procedure for protection of people from abuse. They also had the contact details of the London Borough of Islington which is the authority in which the service was located. The members of staff we spoke with said that they had training about protecting people from abuse and they were able to describe the action they would take if a concern arose.

Requires improvement

Is the service safe?

It was the policy of the service provider to ensure that staff had initial safeguarding induction training when they started to work at the service, which was then followed up with periodic refresher training. Staff training records confirmed that staff had been trained, attended refresher training or were due to attend refresher training. Those whose training would soon require updating had also been identified. On the second day of our inspection we saw that ten staff were attending a safeguarding adults training session.

At the time of this inspection there were no safeguarding concerns. We found that where concerns had previously arisen that these were responded to properly.

Where people were identified as at risk of pressure sores we saw that detailed and clear information was provided to staff to minimise this risk. Actions included provision of air mattresses and instructions concerning the monitoring of these, regular recording of a person's weight, their need for fluids and a balanced diet, checks required on skin integrity and the application of barrier cream. We did note however that this was a standard list of actions for each person assessed with this risk. We checked the recording of weight for people and the records of checks kept on those beds which required the air pressure ratio to weight to be monitored and found that the correct air pressure was being used. This showed that staff had instructions about how to minimise the risk of pressure sores and carried out the routine checks required.

During our inspection we looked at 12 care plans. We found individual risk assessments for personal hygiene, mental health, tissue viability, moving and handling, falls and the use of bed rails had been carried out for each person. There were also care plans and risk assessments in place for people who required palliative care. Risk assessments were being reviewed each month.

The provider may wish to note that we found one person's risk assessment for bed-rails showed that the person had refused the use of the device. There was a care plan in place to deal with the risk associated with this, which included hourly checks. A nurse told us these checks were carried out however they were not being recorded.

During our visit we checked the communal areas of the service which were all clean and well maintained. We were shown records of health and safety checks of the building and the appropriate certificates and records were in place for gas, electrical and fire systems. We saw that hoists and slings used to support people with transfers were regularly checked and these checks were up to date to support people's safety. The provider had emergency contingency plans for the service to implement should the need arise.

We saw that people were supported with their medicines and these were stored safely. The designated nurses for each floor were the only staff permitted to provide medicines to people. On the day of our first visit we observed medicines being administered after lunch on the first floor. We saw that the nurse talked with people about their medicines and they had been given information about what their medicines were for. Records showed people's need for support to manage their medicines was assessed and reviewed as their needs changed.

We looked at ten people's medicines administration record charts and saw that nursing staff had fully completed these. The records showed that people had received all their medicines as prescribed at the correct times of day. We saw that nursing staff were trained in supporting people with their medicines and there were guidelines in place to ensure that people received these appropriately. Records showed staff had followed this guidance and the service also had their medicines management audited by the service.

Good

Is the service effective?

Our findings

Records showed that staff received regular training, supervision and appraisal to ensure they had the skills and knowledge to meet the needs of people using the service. Staff attended regular training which included infection control, safeguarding adults, moving and handling and fire safety. A fire safety training session took place on the second day of our inspection. All of the staff we spoke with at various levels of role and responsibilities told us that they had effective training and that more opportunities had arisen since the new manager had been appointed.

Staff also told us they received supervision every two months. When we looked at staff supervision records we found this was usually happening consistently. With nursing staff having more regular clinical supervision and practice observations. The staff we spoke with found this time helpful in support of their work and had a good understanding of the aim of supervision.

Senior staff understood their responsibilities under the Mental Capacity Act 2005. Senior staff were also aware of the Deprivation of Liberty Safeguards. The care staff we spoke with were able to tell us what these areas meant in terms of their day to day care and support for people.

Where Deprivation of Liberty Safeguards decisions had been approved in the service, these usually being made in terms of the use of bedrails and the poor physical health of people whose physical condition prevented them from providing informed consent, the service had notified CQC accordingly. We confirmed this by looking at the number of approvals listed by the service in comparison to the information that we had been supplied with.

Care plans were being reviewed with people using the service, including family members, and we saw each person had an advanced care plan in place for end of life care. This stated the person's wishes in terms of being admitted to hospital and whether they wanted to be resuscitated. We found that in most cases people had Do Not Attempt Resuscitation (DNAR) orders in their care plans if they had stated they did not wish to be resuscitated in their advanced care plan. One person's DNAR was completed in March 2015. However it had not been signed by themselves or a relative and the provider. The registered manager told us relatives had not visited this person in a while and they wanted to ensure they were involved in this process along with the person in question.

Throughout the day, tea, coffee or juice was offered regularly. When someone asked for tea outside the tea trolley times, it was immediately made for them and they said they could have a cup of tea, "anytime I want."

Everyone was positive and highly complementary about the food and felt there was an adequate choice of dishes. People told us "Oh it's lovely, lovely, it's all cooked fresh on the premises", "If you don't like something, they'll get you something else. You never have to eat it if you don't want it" and "I had a good lunch," and then joked with a carer who had entered the room that, "If I don't like the food, I like the people who bring it."

A relative of someone who used to use the service but still visits regularly said, "The food is very good." Their relative had worked professionally in catering and had enjoyed the meals and this relative concluded, "if even they liked it, it must be good."

There were menus clearly displayed on notice boards and on each table in the dining room. Before being served, each person was shown the menu and asked what they would like. The one outstanding element of care observed came during lunchtime from the chef at the service who took an impressive pride in their work. Their attitude to people was thoughtful and caring and contributed to lunch being a pleasant and sociable occasion rather than just a task. The chef said it was important for them to see that food was presented nicely and to get people's reaction to each dish. They were clearly aware of their likes and dislikes and adjusted portions accordingly.

None of the people in the dining areas needed assistance eating although one took little interest in their food and barely touched the meal. A care worker and the chef both checked on this and encouraged them to eat. They were offered a sandwich as an alternative to the hot meal. They replied that they weren't hungry as they had eaten a big breakfast and the staff were satisfied that was the case and respected their wish not to eat lunch.

We found that nutritionist advice was available from the local health care services when required and the service had sought this advice when assessments and advice were judged by care staff to be needed.

Good

Is the service effective?

The home was periodically visited by the local authority in partnership with the local NHS trust specialist nursing team. This team visited all care homes within the London Borough of Islington to randomly sample care plans for the action each service took to address areas such as tissue viability, care planning and assessment and nutrition. At the most recent visit to this service in April 2015 the team had responded to specific concerns raised about staffing levels which we have already referred to earlier in this report. The most recently published quarterly audit in January 2015 had found that the service was performing well in managing other healthcare needs.

People were supported to maintain good health. A relative told us that when other members of the family had visited and been worried about their relative's health, the staff, "called the doctor immediately."

Nurses were on duty at the service 24 hours and a local GP visited the home each week, but would also attend if needed outside of these times. Staff told us they felt that healthcare needs were met effectively and we saw that staff supported people to make and attend medical appointments, for example at hospital.

Good

Is the service caring?

Our findings

People spoke positively about their care and about care staff generally. They told us "the carers are very nice", "they [staff] are lovely" and another said of their key-worker when she entered the room, "she's a good friend." Others told us "every day here's been very nice," and described the service was "as it should be", and "the care's good. It's not an easy job and we're quite demanding." They said there were sometimes some language difficulties given the different backgrounds of the various staff but that "their hearts are in the right place. They're interested in you being happy."

A relative told us "my [relative] thinks they're all lovely." However, another was upset that that morning a nurse had "shoved" a hospital referral letter at them and then walked off. There had been no attempt at conversation or explanation and no consideration that the relative might want to discuss the contents of the letter. "It was down-right rude," the relative said. We raised this with the manager who said they would speak with the nurse in question about appropriate attitudes being displayed.

Interactions observed demonstrated that staff were gentle and considerate when attending to people's needs. However, on the first floor on the first day of our inspection where fewer staff were present, these interactions tended to be task based and little social interaction was observed.

There were notable exceptions, particularly on the second floor where it was evident that some staff knew people very well and had developed meaningful relationships. For example, we saw a care worker go into the room of someone to make sure they were comfortable after lunch and turn the television on for them. The care worker knew to immediately put the channel on to a rugby match because they knew the person loved sport. The two then talked about their love of sport. Later, we saw the same care worker sit and talk with someone in a purely social, non-task related conversation.

In the afternoon, a friendly conversation was observed between another care worker and three people in a lounge. The carer prompted people to remember things by asking questions about their children and their own upbringings. There was lots of laughter and joking and a very warm, sociable atmosphere.

We spoke with members of the care staff team about how they sought the views and wishes of people who used the service. All of the staff we spoke with described the people they cared for in a respectful and considerate manner.

Good

Is the service responsive?

Our findings

Relatives visited throughout the two days of our inspection and were made to feel welcome. Someone who visits regularly despite their relative having passed away said, “they’re always very welcoming and pleasant.” They recalled the efforts the activities coordinator had made to support their relative who had been unhappy at her loss of independence.

We saw that prior to the admission of people to the service, a detailed care needs assessment had been carried out. This meant that the manager could be sure the needs of the individual would be met at the home, before offering them a place. In addition, the assessment process meant that staff members had some understanding of people’s needs as soon as they started to use the service. People’s care plans were detailed documents, which included details of health professionals involved in their care such as the GP and social worker.

People’s care plans provided evidence of effective joint working with community professionals. We saw that staff were proactive in seeking input from professionals such as the tissue viability nurse and dietician to ensure people received safe and effective care and to reduce the risk of mal-nutrition.

A care worker said that meetings with people using the service and relatives were held, which we confirmed. These had, however, lessened in frequency over recent months. We talked with the new manager about this who told us that these were to be re-established as a regular feature as a part of an improvement plan to the service.

People’s individual care plans included information about life history, cultural and religious heritage, daily activities, communication and guidance about how personal care should be provided.

One person told us they go out “when my children come round.” This person was sitting in their room on their own and said “I do get a bit bored.” We also raised this with the manager who said they would ask the staff on the floor where this person lived to talk with them about activities and see what could be done to make their day more stimulating.

During the morning a music and movement activity session was observed in the first floor lounge. This was led by an external specialist and though attended by only ten people, was very well received. Over lunch some people spoke about the session concluding that it was hard work but good for them. Later, someone said of the instructor, “they’re very good, she gets everyone involved.” This person also talked about concerts and other events they enjoyed including regular visits by local school children who sang and played games with them.

In the afternoon of the first day, a regular art therapy group was observed. Again, an external provider came in to work with people on artwork of their choice. The session was well led with the provider taking time to consult people about how they were feeling, what they felt like doing and to help them use the right equipment. Only a few people attended but one, who had never been before was encouraged to do so and made to feel welcome. On the second day we saw that a concert was taking place by a performer who regularly visited, this seemed very popular and far more people attended and joined in.

People told us that they knew about activities that took place. Some people told us that they found it difficult to leave their room for activities, particularly for people who were bedbound, but they were visited for one to one time by an activities coordinator, which we saw happening. Activities included regular visits by entertainers apart from the other activities referred to earlier.

We asked other people if they went out of the home regularly, they said they were dependent on their own relatives to do that. One relative we spoke with felt this was a serious failing at the home. They said their relative had become increasingly depressed as they loved going out and they could not manage their large wheel chair so couldn’t take this person out themselves. They pointed out that the service had a minibus but said there had not been a driver available for several months. We raised this with the manager who said the handyperson used to also be employed as the mini bus driver but had left. They told us that this position was to be recruited to as a priority as it was acknowledged that it placed a limitation on people’s opportunity to take trips outside of the home.

We asked people about whether or not they knew how to complain and if they felt confident that they would be listened to. People felt confident they could complain although most said they had never felt the need to. We looked at the complaints that the home had received since our previous visit in June and July 2014 and found that very

Good

Is the service responsive?

few comments of concern were made and often comments were received praising the quality of care and the overall service provided. One person who visited the service had raised regular issues with the home about the care of the person they visited. We found that in response to this the home had put into place a system for regular communication and feedback to respond to anything that the person raised. The home had also liaised with the local authority over these issues. The provider had a clear complaints and comments system which was reviewed by the manager and the service provider.

Requires improvement

Is the service well-led?

Our findings

None of the people who were using the service or their relatives who we spoke with made specific comments about the management or leadership of the service. A service user guide was available and this was displayed, along with information about the provider organisation and how to provide feedback and comments about the service.

There was a clear management structure in place and staff were aware of their roles and responsibilities. Staff felt comfortable to approach the manager and senior staff. One, who had started working at the home shortly before our previous inspection told us "My induction went really well and I love working here." Another member of staff told us "the new manager is approachable, strict but that is all to do with ensuring that we maintain standards of care" and "after the changes over the last year I think it feels a lot safer here and staff really do care."

We found that there was clear communication between the staff team and the managers of the service. People's views were usually respected as was evident from conversations that we had with people and those that we observed. Staff told us that there were meetings, which we confirmed, where staff had the opportunity to discuss care at the home and other topics. We saw that staff were involved in decisions and kept updated of changes in the service and were able to feedback their views and opinions through daily staff handover meetings.

One area of concern arose out of a visit to the second floor lounge shortly after lunch. The lounge was empty but the care files of three people were left on a side table where anybody could have read them or written in them. Nobody came to put them away and it was unclear if any member of staff realised they were there. We also found that the nursing station on the second floor was left unattended for a period of time and the cupboard in which people's care plan records were kept was left unlocked with the door open. This is in breach of Regulation 10 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a system for monitoring the quality of care. The home was required to submit regular monitoring reports to the provider about the day to day operation of the service. Surveys were carried out by an independent survey company on behalf of the provider. The most recent published survey was in in December 2014 and this showed that the vast majority of people using the service and relatives had a marked degree of satisfaction with how the service was run. Views from stakeholders were also gathered although this was on a continuing basis as well other professionals, for example the local NHS trust nursing team, social workers and the local authority had regular contact with the service. Feedback that CQC had received since the previous inspection showed that although some difficulties had been evident in the autumn of 2014 these had been addressed and the performance of the service had since shown marked improvement.

The provider had an organisational governance procedure which was designed to keep the performance of the service under regular review and to learn from areas for improvement that were identified. We found that the service received reports after each of these monthly reviews were carried out and the manager was required to report on action to be taken from the findings. We found this was happening and was followed up at subsequent performance reviews.

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	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **Staff were not always readily available to identify and respond to immediate assistance that people required in the communal areas of the home.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Regulation 10 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **The confidential care and personal information records for people using the service were not always kept securely and this permitted potential unauthorised access to them.**