Century Healthcare Limited

Lytham Court Nursing Care Home

Inspection report

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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

Lytham Court Nursing Home is registered to provide nursing care to a maximum of 33 people with dementia conditions. Communal areas include a large lounge with a dining area and a conservatory. There is a passenger lift to access the first floor. There are a range of mobility aids and other aids and adaptations to meet the needs of people living at the home. There is a well-established garden and parking is available on the road outside the home. The home did not have a registered manager. The previous registered manager left the employment of the home in September 2015. The acting manager has applied to be registered with CQC, and his application was being processed at the time of our inspection visit.

Management review meetings were held to analyse the performance of the service and review its objectives. There was a wide range of policies and procedures in place which provided staff with clear information to guide them on good practice in relation to people's care. We found written evidence to show that the acting manager had an appropriate system in place used to assess and monitor the quality of the service. Surveys were sent out to all the people who received a service, and other stakeholders on an annual basis. The feedback contained within the surveys showed that the service was consistently meeting its objectives. Any issues raised via the surveys had been addressed via an action plan.

The service had policies in place in relation to the Mental Capacity Act 2005 (MCA) and depriving people's liberty, and these were put into practice. The building was found to be in a good state of repair, and the environment was found to be fit for purpose. The service had procedures in place for dealing with allegations of abuse. Staff were able to describe to us what constituted abuse and the action they would take to escalate concerns.

Employees were asked to undertake checks prior to employment to ensure that they were not a risk to vulnerable people; the records relating to these checks were complete. Risks associated with medicines management, infection control and cleanliness, and environment factors were assessed. Satisfactory control measures were in place.

People were able to express their choice in relation to meals and how they spent their time. The menu offered people a choice of meals and their nutritional requirements were met. People knew how to access the complaints process, and know who to talk to if they wanted to raise a concern. People who lived and worked at the home were fully aware of the lines of accountability at the home. Staff spoken with felt well supported by the management team. The systems operated within the home relating to how information was processed and how systems were audited was satisfactory. The systems assisted staff to identify areas of service delivery that required improvement and to mitigate risks. People were treated in a kind, caring and respectful way.

There were systems in place to ensure people were involved in their own care planning and support. The training records showed that staff had received awareness training on the subject of end of life care. If people were found to be in need of end of life care, there were systems in place to support this. Staff had

access to on-going training and supervision to meet the individual needs of the people they supported. We found that measures were in place to ensure staff received update training and we saw documentary evidence to support this. We saw written evidence that staff supervision was taking place and we were satisfied that appropriate measures were in place to support the staff team.

There were systems in place to ensure people's needs were assessed, and their care planned for. The addition of one page profiles relating to each individual living at the home would allow staff to quickly see what people's needs were, the risks related to their care and what their interests were. Activities linked to people's assessed needs, abilities and interests were available.

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.

The service had procedures in place for dealing with allegations of abuse.

Staff were able to describe to us what constituted abuse and the action they would take to escalate concerns.

Employees were asked to undertake checks prior to employment to ensure that they were not a risk to vulnerable people; the records relating to these checks were complete.

Risks associated with medicines management, infection control and cleanliness, and environment factors were assessed. Satisfactory measures were in place.

Is the service effective?

Good

The service was effective.

The menu offered people an excellent choice of meals and their nutritional requirements were consistently met.

People's health care needs were met in consultation with relevant health professionals when required, and the service was involved in an innovative speech and language therapy (SALT assessment scheme using Skype.

Staff had access to on-going training and supervision to meet the individual needs of the people they supported.

The service had policies in place in relation to the Mental Capacity Act 2005 (MCA) and depriving people's liberty, and these were put into practice.

The building was found to be in a good state of repair, and the environment was found to be fit for purpose.

Is the service caring?

Good

The service was caring.

People were treated in a kind, caring and respectful way.

There were systems in place to ensure people were involved in their own care planning and support

The training records showed that staff had received awareness training on the subject of end of life care.

If people were found to be in need of end of life care, there were systems in place to support this.

Is the service responsive?

Good

The service was responsive.

There were systems in place to ensure people's needs were assessed, and their care plan for.

Activities linked to people's assessed needs, abilities and interests were available.

People were able to express their choice in relation to meals and how they spent their time.

People knew how to access the complaints process, and know who to talk to if they wanted to raise a concern.

Is the service well-led?

Good

The service was well-led.

People who lived and worked at the home were fully aware of the lines of accountability at the home.

Staff spoken with felt well supported by the management team.

The systems operated within the home relating to how information was processed and how systems were audited was satisfactory. The systems assisted staff to identify areas of service delivery that required improvement, mitigate risks.

Lytham Court Nursing Care 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.

The lead adult social care inspector for the service undertook an unannounced inspection at the service on 08 February 2016. A specialist professional advisor with a background in older people's care also took part in the inspection. This service was last inspected on 28 May 2014, and was found to be compliant in relation to the regulations it was inspected against. The provider sent us 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.

We spoke with a range of people about the service; this included three relatives, nine people who lived at the home, and five members of staff. We spent time looking at records, which included six people's care records, training records and records relating to the management of the home which included audits for the service. Prior to the inspection we reviewed information sent to us from the home such as notifications and safeguarding referrals.

Good

Is the service safe?

Our findings

People's feedback about the safety of the service was consistently good. The comments we received included, "I feel safe here.", "If you need help you and use the call bell, someone comes right away." and "I always get help with my medicines, and I always get it at the right time." People at the home said that they felt their needs were very well met by staff. One relative said that staff were very helpful, and knew their relative very well. They added that staff were quick to respond to requests for help and that the staff kept people safe.

The policies and procedures relating to how staff would respond to physical and/or verbal aggression by service users were publicised and understood by the staff. Staff confirmed that physical intervention or restraint was not used. Instead, the staff employed distraction techniques when people became confused or aggressive. These were written into people's care plans. When incidents of physical and/or verbal aggression by service users took place, these were recorded, and staff were encouraged to discuss the circumstances of the incidents in order to understand why the incident took place. Discussions also took place to see if there were any lessons to be learnt from how the incident was dealt with.

The home's policies and practices regarding service users' money and financial affairs ensured that service users had access to their personal financial records (where appropriate), and safe storage of money and valuables. The acting manager ensured that service users controlled their own money except where they stated that they do not wish to or they lacked capacity. Information held within people's care records showed that safeguards were in place to protect the interests of people who lacked capacity.

We found that satisfactory procedures for responding to suspicion or evidence of abuse or neglect, including whistle blowing, were found to be in place. The acting manager explained that all allegations and incidents of abuse were followed up promptly and any action taken to deal with the issues would be recorded. We saw documentary evidence of incidents were people had raised safeguarding issues in the past, and these had been dealt with promptly and in line with the home's policies. Discussions with staff showed that they had a good awareness and understanding of potential abuse which helped to make sure that they could recognise cases of abuse.

Information held within people's care records showed that there were policies and procedures for managing risk in place, and it was clear that staff understood and followed them to protect people. We looked at the care files of three people and we found that risk assessments were proportionate and centred around the needs of the person. Staff spoken with told us that they enabled service users to take responsible risks, ensuring they had good information on which to base decisions, within the context of the service user's individual plan and of the home's risk assessment and risk management strategies. We found records to show that risks were assessed prior to admission, in discussion with the service user and relevant professionals. Action was taken to put right identified risks and hazards, and service users were given information and advice about their personal situation, to avoid limiting the service user's preferred activity or choice.

The acting manager had policies and procedures in place to respond to whistle-blowers and concerns raised by service users and/or their families. Staff we spoke with told us that the acting manager and service provider had created an open and transparent working environment where workers felt able to speak up if they witnessed poor practice or wrong doing. The company's Director of Nursing explained that they had a commitment to listen to the concerns of workers, and by having clear policies and procedures for dealing with whistleblowing. Staff we spoke with said that they could approach any member of the management team in order to raise concerns or talk about the problems with the practice of colleagues or visiting professionals.

Staff explained that they were provided with training and information on health and safety issues and they said this helped them to ensure they fully understood the risks associated with the operation of the service. Information contained with the home's management records showed that regular monitoring of risks took place. We saw safety records relating to the maintenance of electrical systems and electrical equipment had been undertaken. Water temperatures were periodically checked, and the risks from hot water/surfaces were identified, and action taken to minimise these risks. The risks associated with falls from windows were dealt through the provision and maintenance of window restrictors.

Information held within the service records showed that the acting manager ensured safe working practices were in place for issues such as moving and handling, fire safety, first aid and food hygiene, correct storage and preparation of food. Staff were provided with training and information to ensure they fully understood the risks associated with these practices. Information contained with the home's management records showed that regular monitoring took place. We saw service records to show that the acting manager ensured the health and safety checks took place. Up to date safety records were seen that related to the safe storage and disposal of hazardous substances and the regular servicing of boilers. These were found to be satisfactory.

The acting manager and Director of Nursing operated a satisfactory recruitment procedure. Two written references were obtained before appointing a member of staff, and any gaps in employment records were explored. The acting manager explained that new staff were only confirmed in post following completion of satisfactory pre-employment checks such as those provided by the Disclosure and Barring Service (DBS), and/or the Nursing and Midwifery Council. This was supported with information contained within the personnel records.

We found that the home had a recorded staff rota showing which staff were on duty at any time during the day and night and in which role they fulfilled. The nurse in charge said that the ratios of staff to service users were determined according to the assessed needs of the service user group. He added that that this was not determined using a recognised tool, but purely on the dependency levels of people living at the home. He added, "If and when people's needs change, then we have capacity to increase the staffing levels to meet this need." Staff working at the home confirmed that from time to time, increases in staffing levels did take place to meet people's needs as and when they changed. We found that the numbers of waking night staff on duty reflected the numbers and needs of service users and the layout of the home. We found that domestic staff and catering staff were employed in sufficient number.

We found policies and procedures in place for control of infection, which included the safe handling and disposal of clinical waste; dealing with spillages; provision of protective clothing and hand washing. Our observations found that the premises were clean and hygienic. We found laundry facilities were sited so that soiled articles, clothing and infected linen were not carried through areas where food was stored, prepared, cooked or eaten. The washing machines had a specified programme that met appropriate disinfection standards. The home had appropriate sluicing facility that could be effectively used to dispose of soiled

material from people's clothing.

We found documentary evidence to show that there was a policy and procedure in place for the receipt, recording, storage, handling, administration and disposal of medicines. The nurse in charge explained that people living in the home were able to take responsibility for their own medication if they wished, within a risk management framework. The Director of Nursing explained that following an assessment, people were able to self-administer medication and would be given a lockable space in which to store their medication. However, where people were assessed as lacking capacity to manage their own medicines, or did not want to, then there were systems in place for the staff to do this.

Records were kept of all medicines received, administered and when they left the home or were disposed of, to ensure that there was no mishandling. We looked at the medicines records of three people and found that appropriate records were maintained for the current medication of each service user. Staff spoken with said that they monitored the condition of the people who were prescribed medicines, and call in the GP if concerned about any change to their condition that may be a result of medication.

Good

Is the service effective?

Our findings

Feedback from people living at the home was positive. Comments we received included, "The staff are very good at what they do.", "I visit most days and there are always enough staff on duty, and when you need to speak to someone, they are always very approachable and available.", "The food here is great: lots of choice, lots of variety and very tasty." and "My relative has been living here for over 18 months, and despite her disability, she has been kept to in good health, and that is down to all the staff here. I have no complaints or grumbles."

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 records showed that following an assessment of the person's mental capacity, which included the involvement of the person, best interest meetings had taken place with relevant professionals and family members to determine how best to support the person. Any potential restrictions place on a person's choice or freedom, were based on a clear assessment of their needs and the risks associated with them. These restrictions formed part of the person's individual care plan.

Staff at the home ensured that service users received a varied and appealing diet, which was suited to individual assessments and requirements. People were offered a choice as to where they would like to take their meals; most meals were offered to people in the dining room, however, people could choose to eat in the lounge or their bedroom. We noted that hot and cold drinks and snacks were available to people throughout the day. Meals, including pureed meals, were presented in a manner that was attractive and appealing. Special therapeutic diets were provided when advised by health care professionals such as dieticians. Mealtimes were observed to be unhurried with service users being given sufficient time to eat. Staff were seen to be ready to offer assistance in eating where necessary, and this was done discreetly, sensitively and individually.

We spoke to the chef at the home who said, "Meals are not only vital for people's health, they provide an important social occasion and contribute to their sense of well-being." We found there to be good information available to people on the meal options available to them. One staff member said, " When we inform people of the choices available to them, they are able to make decisions based on their likes and dislikes, and they also find it comfortable in making requests for other foods that are not on a menu."

Our observations showed that the staff working on the day of our visit were able to communicate effectively

with people living at the home. Staff received induction training which included training on the principles of care, safe working practices, record keeping and reporting concerns and safeguarding. Staff members spoken with confirmed that they received satisfactory training to undertake their work. The acting manager explained that training and development was linked to the home's service aims and to service users' assessed needs and individual care plans. Staff were found to be knowledgeable of the specific conditions or illnesses of service users, and were found to have skills in communication and in dealing with anticipated behaviours. The acting manager ensured that formal supervision of staff took place. He explained that measures were in place to ensure staff received update training and we saw documentary evidence to support this. We saw written evidence that staff supervision was taking place and we were satisfied that appropriate measures were in place to address any staff issues.

The nurse in charge explained that people were supported and facilitated to take control of and manage their own healthcare as much as possible. However, the staff team took on responsibility for prompting people's healthcare, monitoring their condition and arranging appointments for treatments or reviews. A review of the care records of three people showed that people were supported to either attend GP and healthcare appointments, and if they were assessed as unable to leave the building due to illness or disability, then staff arranged home visits.

The acting manager explained that the home was involved in a new scheme to undertake speech and language (SALT) assessments using new technology such as Skype (internet based communication software). SALT assessments are used to assess and treat speech, language, swallowing and communication problems to help people eat and communicate effectively. People who needed to have a SALT assessment were supported to use a computer connected to Skype so that they could have a private consultation with a speech and language therapist based at the local hospital. This was seen to be very innovative and useful in that people were able to access an assessment a lot quicker, and receive professional advice and support.

The location and layout of the home was suitable for its stated purpose. The service had a programme of routine maintenance and renewal for the fabric and decoration of the premises. At the time of our visit, the lounge and dining room were in the process of being refurbished. Although this had caused some disruption in the home, appropriate systems were in place to support people in the home. The dining room and lounge were closed off to service users, and other rooms were being used for people to sit and eat their meals. Satisfactory toilet, washing and bathing facilities were provided to meet the needs of service users; they were accessible, clearly marked, and close to the lounge and dining areas. We observed that grab rails and other mobility aids were provided in corridors, bathrooms, toilets, communal rooms and where necessary, in people's bedrooms. Hoists, assisted toilets and showers were available for people to use.

Good

Is the service caring?

Our findings

Feedback from people about the attitude and nature of staff was positive. The comments we received included, "I feel like the staff are interested in me, and help me to do the things I like to do", "The staff are very kind and supportive.", "My relative is very well cared for here.", "We are involved in the care, and any decisions that need to be made."

People's bedrooms were personalised and contained photographs, pictures, ornaments and other items each person wanted in their bedroom. This showed that people had been involved in establishing their own personal space within the home. People at the home confirmed that family and friends were welcome to visit, and this was confirmed by a relative on the day of our inspection.

Staff confirmed they had received awareness training in end of life care. Nursing staff were involved in more specialised training that was on going. The acting manager explained that the aim of the home was to ensure that all residents received good quality end of life care. One nurse said, "We arrange for staff to be with people, until their family arrive. If we need an extra member of staff we can do this. It's important for us to make end of life a time where people feel comfortable and at ease." People were involved in decisions about their end of life care as much as possible. For example two people had a 'do not attempt cardio pulmonary resuscitation' (DNACPR) order document in place and a care plan giving details of their wishes at the end of life.

We looked at the ways in which people were supported to understand the choices they had that were related to their care and support, so that they could make their own decisions. We spoke to two people at the home who said they were comfortable when expressing decisions about their care. One person said that they could approach the staff or acting manager to discuss issues such as the food, clothing and medication. We spoke to two relatives about how they got involved in the care planning process. One told us that they felt they could influence the care and support their relative received, and explained that they had been involved in significant decisions about their relative's healthcare. Another explained that they had been given the opportunity to have input into their relative's care plan, and had been consulted about changes to the care that had been provided. We found documentary evidence to support this in the care plans and risk assessments.

We observed care workers knock on people's doors before entering rooms and staff took time to talk with people. People were treated with dignity and respect by staff and they were supported in a caring way. Care workers used people's preferred names and we saw warmth and affection being shown to people. People recognised care workers and responded to them with smiles which showed they felt comfortable with them. Tasks or activities were seen not to be rushed and the staff were seen to work at the people's own pace.

The arrangements for health and personal care ensured that people's privacy and dignity were respected. Personal care such as nursing care, bathing, washing, using the toilet or commode were carried out in private. One person confirmed that consultation with, and examination by, health and social care professionals was also carried out in private. Staff confirmed that they respect information given by people

in confidence, and handle information about people in accordance with the home's written policies and procedures. On speaking with staff, it was clear that they knew when information given to them in confidence must be shared, for example, if allegations of abuse were made or if there was a suspicion of crime such as theft.

Staff explained that that no-one at the home used an independent advocate and that most people had the involvement of their family. We saw information for people to use regarding local advocacy services within the reception area of the home. This information was available to people if they had no family or friends to assist them, or if someone wanted an independent person to act on their behalf when discussing issues with others such as the care home, or local authority.

Good

Is the service responsive?

Our findings

The feedback from people living at the home, and their relatives was consistently positive. Feedback we received included, "The staff always have time for me and my relative. Nothing seems to be too much trouble for them."

The people we spoke with said that the care they received was delivered in accordance with their needs and wishes, and the written reviews of this care supported this view. The reviews showed that where possible, the person themselves had been involved, and if this wasn't possible, family members and others important had been consulted. We spoke to one relative about the care planning process, and delivery of care, and they all were satisfied that the staff were following the guidelines set in their relative's care plans, and that this had resulted in their relatives experiencing a good quality of life whilst living at the home.

The home had a suitable complaints policy and procedure that was publicised in the documentation provided to people who use the service. We found that the organisation liaised openly and honestly with complainants, and provided them with up to date and accurate information relating to their complaints. Action had been taken to satisfactorily deal with and resolve complaints.

The nurse in charge said that care staff reported and recorded any issues regarding people's health and well-being, and action was taken to deal with these issues accordingly, either via the nursing staff or through other agencies such as their GP. Staff confirmed that they were involved in supporting people with personal care and oral hygiene. The nursing staff were involved in assessing people who were at risk of developing pressure sores and appropriate intervention was recorded in people's care plans. The incidence of pressure sores, their treatment and outcome was recorded in people's files, and reviewed on a continuing basis. Equipment necessary for the promotion of tissue viability and prevention or treatment of pressure sores was provided.

Information held within the care plans showed that people had been involved in their assessment of need to a lesser and greater degree, depending on their capabilities. This process helped to identify their individual needs and choices, and was based on information supplied by social workers and external healthcare staff. If the person was unable to contribute, information had been actively sought from others such as family members and friends. Written personalised care plans, which detailed people's individual needs and choices, had been put together by the staff and the person receiving the care where possible. Nutritional screening was undertaken on admission and subsequently on a periodic basis, and a record maintained of nutrition, including weight gain or loss, and appropriate action taken. Appropriate interventions were carried out for people identified as at risk of falling

Staff told us that opportunities were given to people to take part in various social and pastime activities. They said that that there were board games available to people to use, entertainers sometimes visited the home, and staff engaged in social chats with people. Staff were seen to engage people in activities such as chatting, talking about the news, reading the newspaper and other activities

The home had appropriate processes in place to ensure that when people were admitted, transferred or discharged, relevant and appropriate information about their care and treatment was shared between providers and services. Information held with people's personal care records showed that liaison had taken place with other health professionals and a relative spoken with confirmed that they had been involved with the assessment process and had been kept informed at every stage. We found written records to show that information was shared in a timely way and in an appropriate format so that people received their planned care and support. The nurse in charge explained that staff worked with other providers and professionals such as district nurses, hospital staff and social workers, to ensure that people's care plans reflected their individual and diverse needs. This was documented. In the event of an emergency, we found details of how information would be shared with other agencies in a safe manner, so as to make sure people received a coordinated approach to support the need to meet the needs described in their care plan. Written records were maintained and appropriate external contact details were logged.

Good

Is the service well-led?

Our findings

The feedback from people living at the home, and their relatives was consistently positive. The comments we received included, "The atmosphere in the home is friendly and welcoming", "The home's manager is always available to talk to".

The home did not have a registered manager. The previous registered manager left the employment of the home at the start of 2016. The acting manager has applied to be registered with CQC and his application was being processed at the time of our inspection visit.

We saw a wide range of policies and procedures in place which provided staff with clear information about current legislation and good practice guidelines. This meant staff had clear information to guide them on good practice in relation to people's care. We found written evidence to show that the acting manager had an appropriate system in place used to assess and monitor the quality of the service. The acting manager explained that he and the Director of Nursing were involved in auditing different aspects of the service provided. We saw evidence of these audits, and saw that the system had flagged up areas of concern, and minor issues relating to care delivery and service provision. We found daily records to show that various people at the home had been involved in incidents that required notification to the Commission and/or the local Safeguarding team, and that notifications had been processed and sent in a timely manner.

The staff we spoke with confirmed that they received regular handovers (daily meetings to discuss current issues within the home). They said that handovers gave them up to date information to continue to meet people's needs, and updates regarding incidents, and what action to take to minimise or reduce the possibility of further accidents or incidents. One staff member told us, "Handovers are great. We have a chance to get up to date information about people's care needs, and this helps in understanding people better."

Staff at the home said that they had understanding of what the home stood for, with one saying, "We try and provide care and support that is dignified, compassionate and safe. The feedback we get from service users, and their families is that we are doing this, and that feels great." Surveys were sent out to all the people who received a service, and other stakeholders on an annual basis. They were seen to cover all aspects of the service, and mirrored the questions asked by CQC during an inspection. The return rate for surveys was very good, and the comments were very positive. The feedback contained within the surveys showed that the service was consistently meeting its objectives. Any issues raised via the surveys had been addressed via an action plan.

The people we spoke with on the day of our visit (people living at the home, staff and relatives) all said that the acting manager and management team provided good leadership. People said that the acting manager was knowledgeable, and that he was able to deal with issues in a positive manner as they arose. The staff we spoke with clearly understood the lines of reporting and accountability within the home. When we questioned staff they were able to give a good account of their roles and responsibilities with reference to keeping people safe, meeting people's needs and raising concerns regarding the quality of care provided at

the home.

We saw that management review meetings were held to analyse the performance of the service and review its objectives. We saw the agenda for the latest meeting which included areas such as; review of service users information, results of internal audits, resource needs, staff training and evaluation, client feedback and recommendations for improvements. The service had a business plan in place. This included the current management structure, objectives of the service which covered staffing, recruitment, meeting service users' needs, audits and building renewal and repair. Any issues raised had been addressed via an action plan and work was on-going.