Westward Care Limited

Southlands 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

The inspection took place on 16 and 17 October 2017 and was unannounced. At the last inspection in April 2016 the service was rated 'requires improvement' because staff were not always given the necessary skills and training to care for people and there was a lack of activities for people to participate in. At this inspection the service made the required improvements.

Southlands Nursing Home is a care home for older people; and is registered to accommodate up to 36 people. The accommodation also includes self-contained apartments. It is located in a suburban area of Leeds within walking distance of Roundhay Park and with good transport links and local amenities nearby. There were 17 people living in the service at the time of the inspection.

At the time of the inspection, the service had a registered manager. 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.

People told us they felt safe living at the service and that there were enough staff to meet their needs. Staff were recruited safely, and staff knew how to protect people from abuse using the systems and processes provided by the service.

People were given their medicines safely, with accurate records made. Medicines were ordered, stored and disposed of safely.

Staff were given an induction that equipped them with the knowledge and skills to support people safely. Training needs were monitored by the registered manager and staff were supported with supervisions and appraisals to identify further training opportunities.

People were supported to access medical professionals where required. People were supported to maintain good health through a nutritionally balanced diet. Their weight and nutritional intake was monitored appropriately.

People told us they were cared for by kind and attentive staff, who gave due consideration to their privacy and dignity. People told us they were independent, and staff facilitated them to be as independent as they wanted.

There was a good range of internal and external activities for people living at the home. People told us they participated in interesting and varied activities, and that the activities coordinator, who had been employed since the last inspection, had made improvements to people's social lives and wellbeing.

There was a robust complaints procedure at the home, and people told us they were confident they knew

how to raise a complaint. Complaints we reviewed were given appropriate attention and acted upon by the registered manager.

There was a positive working culture, and staff told us they were confident in the leadership of the service. Staff told us they felt listened to by the registered manager and we saw regular staff meetings were held where staff participated openly.

There were appropriate mechanisms in place to monitor the quality of the service provided, and the registered manager was given good support by the provider.

The service proactively sought feedback from people living at the service through surveys, questionnaires and 'relatives and residents' meetings.

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.

There were enough staff to look after people living at the service. People told us they felt safe.

There were checks in place during staff recruitment to ensure staff were safe to care for vulnerable people.

Medicines were ordered, administered, recorded and disposed of appropriately.

Is the service effective?

Good

The service was effective.

Staff were given an effective induction and mandatory training programme which was monitored by the registered manager.

People were supported to maintain a healthy diet and were supported by staff who monitored their nutrition and weight where necessary.

People were supported to access healthcare professionals and referrals were made to health professionals on people's behalf when needed.

Is the service caring?

Good

The service was caring.

People were cared for by kind and attentive staff who knew their preferences.

People's privacy and dignity were respected at all times.

People were supported to live independently and given choices as to how they wanted to be cared for.

Is the service responsive?

Good

The service was responsive.

There was a varied programme of activities and people were supported to maintain links with those who were important to them.

People's care plans were written in a person-centred way with clear guidelines for staff on how to care for people. Care plans were regularly reviewed.

There was a robust complaints process and people knew how to make a complaint.

Is the service well-led?

Good

The service was well-led.

There were systems and processes in place to monitor the quality of the service.

Staff were confident in the leadership of the service and felt the registered manager was open and transparent.

The service gathered feedback from people, their relatives and staff on the quality of care through meetings, surveys and questionnaires.

Southlands 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 16 and 17 October 2017 and was unannounced. The inspection team consisted of one Adult Social Care inspector, one assistant inspector, one senior analyst and an expert-by-experience who had experience of people living in a nursing environment. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

At the time of the inspection there were 17 people living at the home. We spoke with nine people who used the service, three relatives and six staff, including the registered manager, kitchen staff, senior nurses and care staff. We also spoke with a visiting health professional. We looked at documents relevant to people's care and support and the management of the service, such as quality audits, medicine administration records and risk assessments. We looked at five people's care plans.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This document asks the provider to give key information about the service, what the service does well and any improvements they plan to make. We reviewed all the information we held about the service. This included any statutory notifications that had been sent to us. We also contacted the local authority and Healthwatch for any information they had about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe living in the home. One person told us, "Yes, I feel very safe. They check you and make sure you are getting up okay." Another person told us, "We have fire drills and I have doors I can lock. They keep a sharp eye on what's going on, people can't just wander in."

Staff were able to describe how they would protect people from abuse, and they understood how to raise safeguarding alerts. One staff member told us, "We could report it to CQC, and the local authority. Abuse can be physical, financial, sexual and emotional. If I saw it I would escalate it to the manager, and if it was a concern about the manager I would go to the regional manager." The service had an up to date whistleblowing and safeguarding policy which was accessible to staff. Accidents and incidents were recorded and investigated appropriately, and were analysed by the provider for any trends or themes.

There were enough staff to deliver care safely. The service used a dependency tool to calculate how many staff were required to provide appropriate care for people. The registered manager had recently introduced a 'Twilight shift' because they identified call bell response times increasing during handover, so had introduced this shift to ensure everybody's needs could be met while handover was taking place. Staff generally agreed there were enough staff on duty, one staff member told us, "[Staffing levels] seem to be alright", and another staff member said, "There are always six carers and a nurse on duty, this is generally fine." Another staff member we spoke with said, "I don't know, maybe we need more. I would be pleased to have another person." People we spoke with told us there were enough staff. One person told us, "Yes, sometimes it's a bit short on a Sunday but usually it's pretty good."

We found recruitment practices were safe and relevant checks had been completed before staff worked unsupervised at the home. These included identity checks and a disclosure and barring service check (DBS). The DBS is a national agency that holds information about people. This helped to ensure people who lived at the home were protected from individuals who had been identified as unsuitable to work with vulnerable people. The manager also reviewed a regularly updated list from the Nursing and Midwifery Council of ongoing investigations to ensure that additional checks could be carried out on nurses if required.

We saw medicines were ordered, stored, delivered and disposed of safely. Medicine Administration Records (MARs) were used to clearly record medicines given to people. Each person's MAR had a photograph of them to reduce the risk of administration errors occurring, as well as information on any allergies they might have. MARs gave clear instructions for staff on what medicine to administer; in which dose and at what time. Where medicines were refused this was clearly recorded with reasons given. MARs also included copies of people's medicine support care plans. We saw one which gave clear guidance for staff on how to administer medicines to people the way they wanted, for example in one support plan staff were instructed: '[Name] would like staff to give plenty of time to swallow tablets with water.'

People were also prescribed PRN medicines (this means medicines which are directed to be taken 'as required') and there were clear guidelines for staff on how to record them appropriately. For example to ensure the time of administration was recorded in order to prevent possible overdose. We found PRN

medicines guidelines were followed by staff to ensure safe practice . Where people were prescribed transdermal patches and ointments, the service used topical MARs (TMARs), which included body maps so it could be clearly identified where the medicines had been applied.

Medicines were stored in an air conditioned secure room, and the room temperature was regularly monitored. There was a fridge for temperature sensitive medicines, and we found the temperature was also recorded daily. Controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse); were stored securely and an accurate record of stock was held. Appropriate disposal arrangements were in place.

Risks to people were assessed and managed appropriately. We saw in people's care plans there were risk assessments for a wide range of health and safety concerns such as falls, bed rails and mobility. The service used nationally recognised tools such as the malnutrition universal screening tool and Waterlow score to risk assess malnutrition and skin integrity respectively. They included information on how people were at risk with guidance for staff on how to reduce this. Risk assessments were regularly updated to ensure their continued effectiveness.

We saw people had personal emergency evacuation plans with clear guidance for staff on how to safely evacuate people in the event of an emergency. The service also carried out regular maintenance checks on equipment such as hoists and wheelchairs, as well as fire alarms and lighting systems. The service had up to date gas and electricity safety certificates in place, which indicated they had been assessed as safe by a professional.

The service had a business continuity plan with clear protocols for staff to follow should scenarios like power failures, water system failure and extreme weather events occur. There was a thorough fire safety risk assessment with pictures and diagrams of the fire safety systems and plans to reduce the risk of fire. We saw fire drills took place on a regular basis.

Good

Is the service effective?

Our findings

People told us they were cared for by trained, competent staff who understood how to meet their needs. One person told us, "I am very well looked after."

We reviewed the staff training records. Mandatory training included moving and handling, safeguarding adults, infection control and fire safety training. The registered manager used the training record to identify whether training had been completed and when it was due for renewal for individual staff. One staff member told us, "I've recently done fire safety, moving and handling and safeguarding training refreshers. I am confident the manager would inform me if my training needed updating."

Staff were given an effective induction during which new staff were supervised by a mentor. This included mandatory training and an introduction to people using the service, which involved reading their care plans. Staff told us they felt their induction was useful in preparing them to carry out their role. One staff member said, "I had a mentor. I did a month of training and had a book with things I needed to know. I was always supervised; after the induction I was allowed to work unsupervised."

Staff were supported with regular supervisions and annual appraisals, and staff told us this was useful. One staff member said, "Yes, we have plenty of them. I've had two supervisions and an appraisal. I also have informal supervisions with the manager when I need them. The manager is great about it (the informal supervisions)."

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)

The service made DoLS applications appropriately and kept an accurate log of their application and expiry dates, and followed up any applications that had not been processed by the local authority.

The service employed two mental health nurses who assisted with mental capacity assessments and best interests decisions. We saw these were decision specific. Staff were trained in the MCA as part of their mandatory training. One staff member described their understanding of the MCA. They said, "It is to protect people with mental health conditions, conditions which affect retrieval of information, and taking decisions. DoLS is a part of MCA, making sure people are safe. Mental health assessments take place here." Another staff member said, "It's about protected people who can't make decisions for themselves." Information such as the five principles of the MCA were available in staff rooms for staff to refer to. Consent forms were located in people's care plans and we observed staff asking people before delivering care.

We observed lunch at the service. Food looked appealing and the temperature of food was recorded before being served to make sure it was warm enough. The meal was served in three courses, with two choices of starter and main offered. People we spoke with told us they enjoyed the food. One person said, "It's always good, it's hot when it's meant to be and cold when it's meant to be and we get a choice of sweets."

People had their weight monitored regularly and where staff noted a decrease in weight, appropriate health professionals were referred to. People's care plans included detailed information on their allergies and food preferences.

People were supported to access health care professionals. Care plans contained a detailed log of all professional visits and documentation from them such as eyesight assessments from the ophthalmologist and care plans were updated accordingly. One person we spoke with said, "If you need a doctor, you certainly get a doctor. If you need a dentist too; it's all covered."

We spoke with a visiting advanced nurse practitioner who regularly visited the service; they told us they had no concerns with staff care and competence. They told us staff made appropriate referrals when necessary. They felt staff were very knowledgeable about the people they cared for.

Good

Is the service caring?

Our findings

People told us they were cared for by kind and attentive staff. One person said, "Staff will put themselves out to be kind when they are doing anything." Another person told us, "I think they are extremely helpful, if you wanted something, you can always ask and on the whole they are very helpful."

People told us they were cared for by staff who respected their privacy and dignity. One relative said, "They treated my relative with respect. Staff use people's preferred names. They would close the curtains and ask us to leave. They always inform people what they are going to do before they do it." We asked staff how they protected people's dignity and privacy. One staff member said, "We always cover people while we wash them and lock the doors. We always knock on doors before entering."

We saw evidence people were supported to access advocacy services, and information on how to access advocacy was clearly available in the reception. We saw people had their advocates listed in their care plans and they were recorded as being included in relevant updates to their care, such as best interests decisions, where necessary.

People told us they were supported to live as independently as possible, with their choices respected. One person told us, "When I have a bath; sometimes they (the staff) will say would you like a bath. They are very good. It is your choice. You have to tell them. They also test the water for you." Another person said, "Yes, I'm very independent." We asked one person if they could choose when they wanted to go to bed and get up, they said, "You can please yourself depending on what's happening in the day. If I wanted a lie in, nobody would stop me." Staff told us they always offered people choices throughout the day. One staff member said, "We ask people what they want to eat, wear, and when they would like to have a wash. We ask them when they want to get up. One lady I look after has a shower every morning." We reviewed a care plan which included clear instructions for staff to support a person to maintain their independence, stating, 'It is very important to [Name] to feel clean and fresh and look smart and she will choose what she wants to wear. [Name] would also like staff to respect her wishes should she not want to get dressed.'

We saw people were supported to maintain contact with their loved ones and participate in social activities. Everyone we spoke with told us they had visitors whenever they wanted, and one person was supported to go to their local church. We asked staff how they supported people to maintain contact, and one staff member said, "Usually family and friends come to visit. We help people to make calls, and one resident has a tablet computer with a video camera so we help them make video calls to their family on it."

Documentation in care recorded held information about people's protected characteristics, such as their religious beliefs (including how they wanted to be supported to practice or not practice according to their wishes), cultural background and sexual orientation. Where people did not want to have this recorded, this was also noted. Staff were confident they would be able to respect and cater for people with diverse needs, for example the registered manager told us that when a person who was Jewish had died staff knew not to touch their body in accordance with their faith. The chef told us they were able to order halal and kosher food if needed, and the chef held accreditation from an official body to cook kosher meals. Staff were given

equality and diversity training as part of their mandatory training programme. This meant that the service was working within the principles of the Equality Act (2010).

The service received a number of compliments and cards of thanks to the staff from people who used the service and on behalf of them. One complement we read said, 'A big thank you to all the staff for the love and care you gave to [Name]. We are so grateful for the patience and extraordinary care you gave her.'

Good

Is the service responsive?

Our findings

Since our last inspection, the service had appointed a dedicated activities coordinator. People told us they enjoyed the activities offered and spoke highly of the activities coordinator. One person told us, "[The activities coordinator] is a very good organiser. We have 'Knit and Natter' today. I've been on several trips; one of them was a visit to the opera; some people weren't sure before they went but they loved it." We saw the activities coordinator devised a weekly plan of activities such as pamper days, reminiscence and games. When we asked how they would accommodate people who did not want to leave their rooms or participate in group activities, they told us, "I have one to one sessions. We might play Scrabble or talk or play music, whatever they want to do; it's all about their choice. I have an activity book and I ask staff members to write to show that they are doing something. We add how people are feeling."

We saw there were other activities taking place in addition to the weekly plan which involved people being taken to places such as York Castle and Kirkstall Abbey market or having people and entertainers come into the service such as local school children and a gent's barber. The activities coordinator recorded the number of people involved, feedback from people and staff, and a comment on whether the activity was likely to be well received again if it was repeated. For example, where 15 people attended an opera recital the activity coordinator noted that, 'Our residents all joined in singing along and doing the actions. Our residents couldn't wait for them to come back.' One person told us, "I take part in most activities; the opera, Lavender Farm, Temple Newsome. There are two buses hired to take wheelchairs." Another person said, "We get a lot of people coming like singers. The activities coordinator has a clipboard (to gather people's views) and if we think they are not so good she will tell us they are not coming again." This meant that there were a range of activities which took into account people's likes and dislikes.

People were assessed before entering the service to ensure their care needs could be met. Assessment documents recorded some information about the person's life history, medical history and close family. People's care plans also included relevant discharge letters from hospitals and mental health teams which enabled the registered manager to make informed decisions about how the service could meet people's needs.

We reviewed five people's care plans and found they were written in a person centred way. Care plans included life histories which gave a background of their work life, childhood and relationships. They included photographs of their named nurse and key care worker. Care plans recorded people's likes and dislikes, and their hobbies and interests. There were clear instructions for staff on how to care for people in a way they wanted. For example, we saw one person who wanted to be positioned in a certain way in bed, and in their care plan there were photos taken of the person demonstrating this with clear step-by-step instructions for staff on how to help them.

Care plans were regularly reviewed, and were also reviewed in response to an incident or change in circumstances. For example, in one care plan we saw that in the daily notes, staff had noted a person had trouble swallowing food at mealtime, and that they had referred the person to the speech and language therapy service that day. It was recorded that the speech and language therapy service saw the person the

next day, and the care plan showed all advice from the service was reflected in the person's updated care plan.

We saw relevant people were included in reviews of people's care. We spoke to three relatives of people who used the service and they told us they were as involved in their loved ones care as the person wanted them to be. One relative said, "They came and did a review with us once. There should have been a second time but I couldn't go." We saw a care plan review which noted the person's advocate was also present.

People told us they were confident they would raise any concerns or complaints with the registered manager. One relative told us, "They are approachable. We had an issue and staff sorted it out. Anything raised has been dealt with." There was a clear policy on how complaints were to be responded to with timescales to be followed. The complaints file showed verbal complaints were recorded and investigated as well as written complaints. There were nine complaints in 2017, and we found all of them had been responded to within the service policy's guidelines and all people who had made the complaints were satisfied with the outcome.

Good

Is the service well-led?

Our findings

The service had a registered manager in post at the time of the inspection. People and staff told us they were confident in their leadership and that they were approachable and receptive to any concerns. One person said, "[Registered manager] knows everyone. [Registered manager] greets me by my first name and has tabs on everyone. [Registered manager's] not obtrusive, [they're] helpful." One member of staff told us, "I'm relatively new here but straight away they asked my opinion and listened to my suggestions." Another staff member said, "You can go to see [registered manager] at any time. From day one they've been brilliant."

Staff also told us they enjoyed working at the service and there was a positive working culture. There were regular staff meetings, and staff told us they were useful. One staff member said, "We've had about four this year. The manager definitely listens to us. It's open and friendly." Another staff member said, "We have meetings quite often, either in staff groups, for example care staff and housekeeping, or general meetings. We can speak about our ideas with the manager and [they] listen to us." There were two staff surveys in 2017, which were positive overall, and there was an employee of the month award. We asked people if staff seemed positive in their work when caring for them, and everyone we spoke with agreed. One person said, "I think so, there is a lot of laughter here."

We saw the service had robust arrangements in place to monitor the quality of the service delivered and drive any improvements needed. There was a programme of audits and checks which were carried out daily, weekly and monthly. Audits included medicines management, food safety and care plan audits. There was also an external medicines review conducted annually by a local pharmacist which covered areas such as medicines storage, recording and administration of medicines. We reviewed the latest audit and found that there were no advisory actions for the service to take. The registered manager also conducted daily environmental walk-rounds which included checking that up to date information and leaflets were available in communal areas and staff rooms, if there were any odours or issues with cleanliness, and equipment such as wheelchairs for their general condition and suitability. We reviewed the service's most recent accidents and incidents audit which analysed all incidents that had occurred for any trends or themes. This looked at how many of each type of incident, for example falls and skin tears had occurred, and concluded with a section on lessons learned and gave a recommendation on any actions to take. At the last review, staff were instructed to closely monitor falls as these had increased since the last audit, and contractors were called to inspect all hoists because of an incident involving a faulty hoist. This meant that the service was committed to continuous improvement. We also saw all relevant notifications to CQC were made appropriately and in a timely way. These included notifications of any deaths, safeguarding incidents and any serious injuries.

The manager told us they felt well supported by the provider. The registered manager sent a monthly quality report to the provider, including falls, incidents and DoLS applications. These metrics were analysed by the provider to identify any themes or trends where support could be provided. There were no negative trends or comments on the metric reports we reviewed. The registered manager also attended regular meetings with other managers at sister services owned by the provider. We reviewed the minutes for the latest meeting and found that they shared good practice and their experience of incidents at their services.

The service had introduced monthly 'residents and relatives' meetings in 2017. In one meeting held in June 2017 we saw that menus, entertainment, and people's concerns such as a wasp's nest that had grown were discussed with actions agreed to address these. The service also had a 'you said, we did' board which demonstrated that what people suggested had been acted on. For example, on the February – April 2017 notice we saw a clock had been purchased, photographs had been taken of staff to display in bedrooms and that 'resident relative' forums had been introduced as a response to feedback from people. Furthermore, the service sent regular questionnaires to people covering aspects of the home such as privacy and dignity, food, activities and safety. We saw results were overwhelmingly positive. Where there were negative comments, for example in one survey it was noted that a person wanted different food options, the registered manager instructed the catering staff to discuss with them what they could do to further incorporate their preferences into the menu. We also saw that people who used the service were invited to attend interview panels before a prospective staff member was appointed. One person told us, "Yes they asked me if I wanted to attend the interview." This meant that people were engaged by the leadership of the service in a meaningful way.