Arms Associates Limited

Laburnum Lodge

Inspection Report

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Summary of findings

Overall summary

Laburnum Lodge is a care home which provides accommodation and care for up to 22 older people, some of whom have a diagnosis of dementia. The home does not provide nursing care.

We saw that staff were able to deal with an incident in a way that kept the person safe and dignified. However this highlighted that there were not enough staff on duty in the areas within the home to ensure all other people were kept safe.

We heard staff talk with people in a pleasant and encouraging tone, and used the name the person wanted to be called. There were some terms of endearment, but it was evident that people in the home were very happy with that.

There were many visitors on the day of inspection, some of whom stayed for lunch. It was obvious that this was a normal occurrence and meant relative's were encouraged to visit and stay for meals.

There was a new computer system where care plans and risk assessments were written and recorded for people living in the home. The system was word protected which meant people could be assured their information was kept safe.

Although there was evidence that staff had undertaken training such as moving and handling, fire safety, safeguarding and infection control, some competency and skills based training, such as medication, had not been completed. This meant staff responsibilities to deliver care to people safely and to an appropriate standard was not always met.

There were other training courses that had been undertaken by staff, such as dementia and whistleblowing, which meant their learning and development enabled them to provide effective care to people in the home.

The manager said there was no system in place to check the correct levels of staffing necessary. This meant that there were not always be sufficient numbers of suitably qualified and experienced staff on duty.

The service did not always follow current and relevant professional guidance about the management of medicines, and staff did not have sufficient training to enable them to manage people's medicines safely.

There was an annual system in place to assess and monitor the quality of the service by seeking the views of people who live in the home or their relatives and other professional.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS), and to report on what we find. (The deprivation of liberty safeguards are a code of practice to supplement the main Mental Capacity Act 2005 Code of Practice.)

We looked at whether the service was applying the Deprivation of Liberty safeguards (DoLS) appropriately. These safeguards protect the rights of adults using service by ensuring that if there were restrictions on their freedom and liberty these would be assessed by professionals who are trained to check whether the restriction was needed. While no applications had been submitted, proper policies and procedures were in place but none had been necessary. Relevant staff have been trained to understand when an application should be made, and in how to submit one. We found the home was meeting the requirements of the Deprivation of Liberty Safeguards. People's human rights were therefore properly recognised, respected and promoted.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

People living in the home and their relatives told us that most of the time there were enough staff on duty to make sure people were cared for safely. However, we saw that unforeseen circumstances, as well as day to day requirements meant there were times when there were not sufficient staff to ensure all areas within the home kept people safe.

We found that although improvements had been made since our last inspection, the service was not consistently managing medicines in a safe way. The service did not always follow current and relevant professional guidance about the management of medicines, and staff did not have sufficient training to enable them to manage people's medicines safely.

Care plans and risk assessments were updated where necessary which meant people were protected from the risk of harm.

The home had proper policies and procedures in relation to the Mental Capacity Act and

Deprivation of Liberty Safeguards although no applications had needed to be submitted. Staff had been trained by the local authority to understand when an application should be made, and in how to submit one. This meant that people would be safeguarded as required.

Are services effective?

People's health and care needs were assessed and they were involved in writing their plans of care. Specialist dietary, mobility and equipment needs had been identified in care plans where required. People said that they had been involved in writing them and they reflected their current needs. People told us they had been involved in decisions about their care and the staff were quick to consult other health and other professionals when necessary.

People were encouraged to maintain their independence and we saw examples of this during the inspection.

Staff had received appropriate training to ensure they had the knowledge and skills they needed.

Summary of findings

Are services caring?

People told us that staff were very caring and relatives said their family members were well supported by polite staff. We saw that care workers showed patience and gave encouragement when supporting people.

During an incident we observed how a person was treated with dignity and compassion, whilst awaiting the emergency services.

People had their choices and preferences discussed and provided by staff.

Are services responsive to people's needs?

Although people told us their basic needs were met, there were few activities that took place in the home to encourage to maintain hobbies or provide facilities for them. People told us that the activities that had taken place were adequate. The activities co-ordinator only came to the home once a week. This meant people did not have activities available that reflected their personal choices.

There was a complaints policy but there had been no comments or complaints made about the service. All the people and relatives we spoke with knew how to make a complaint if they were unhappy.

Are services well-led?

There was a registered manager in post.

Staff were aware of their roles and responsibilities and were supported by the manager. None of the staff we spoke with had any issues or concerns about how the service was being run.

The staff worked well with other health professionals as was seen on the day of inspection. This meant incidents and accidents in the home were dealt with effectively, although these were not always used to monitor and inform practice.

There was an annual questionnaire so that people living in the home were able to express their

views and opinions about how the service was being run. However the minor changes needed took seven months to be addressed.

There was no effective method used by the manager to ensure that were sufficient number of staff, with the right competencies, knowledge, qualifications, skills and experience to meet the needs of people living in the home.

Audits and checks in relation to medication and staffing levels for example were not completed.

Summary of findings

What people who use the service and those that matter to them say

We spoke with eight people living in the home, and seven relatives who were visiting on the day of our inspection. All the relatives we spoke with told us they were happy with the care their family member received. One relative explained: "They were so friendly to my mum that she has stayed here since her first visit". Another relative said her mother was treated well, saying, "Yes, treated kindly".

One relative we spoke with said that the staff always contacted the relevant health professionals for their family member and then informed them (the relative) immediately afterwards. One relative said: "He always sees the GP, chiropodist and they even called the ambulance. They call anyone out, even on a Sunday".

One person said; "They (the staff) are all nice, I have nothing bad to say about them".

People said they felt the staff were very busy and rushed. One person said: "They don't have time to do talking. The cleaner may talk to me sometimes, and does my bed."

One relative summarised the care saying: "I find the staff very good, I'm just happy all the way round. If there was anything wrong I would complain, they're all very friendly".

Laburnum Lodge

Detailed findings

Background to this inspection

We visited the home on 2 April 2014. This inspection was unannounced which meant the provider and the staff did not know we were coming. Our inspection team was made up of an inspector, a pharmacist inspector and an expert by experience who had an understanding of dementia care.

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 regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process under Wave 1.

Prior to our inspection we reviewed historical data we held about safeguarding incidents in the home and reviewed incidents that the provider had informed us about.

During the inspection process we talked with eight people living in the home, seven visitors, three staff, and the registered manager. We looked at four people's care plans and other documents.

At our last inspection in February 2014 we identified problems in relation to medication. The provider sent us an action plan in March 2014 telling us how they would address this. We looked at medication during this inspection and the necessary improvements had not been made.

Are services safe?

Our findings

People we spoke with said they felt safe and relatives who visited at the time of the inspection agreed. People were safe because safeguarding procedures were in place and staff understood their roles and responsibilities to ensure people in the home were protected. Staff told us they had undertaken training in safeguarding and there was further evidence on the training matrix. Staff said they had attended a course with the local authority and were able to discuss what constitutes abuse and what they would do to raise concerns. All three staff we spoke with said there were clear policies and procedures in the policies and procedures file. They all knew where the telephone numbers for the local authority safeguarding team and other relevant numbers could be located.

There was not an effective system in the home for staff to manage and record accidents and incidents. During the inspection there was an incident when someone fell from their chair. Staff immediately responded and checked the person for any injuries, kept the person comfortable and dialled 999. They then ensured the person's privacy by using a screen to shield them from other people in the home. The incident took place in the dining area and there were no staff present at the time, but the inspector was able to summon help. Once staff arrived one member of staff was occupied with the person who had fallen out of a chair. Another person wanted to leave the home, and was trying to find a way out, which also required staff assistance. There were three staff members and the manager in the home. This meant if anyone required two staff to assist with hoisting, there were no staff to help other people. This meant there were not always sufficient staff on duty to make sure they could respond to unforeseen events. This meant there had been a breach of the relevant legal regulation (Regulation 22) and the action we have asked the provider to take can be found at the back of this report.

The number of staff on duty were detailed on the rota. It showed that there was one senior and two carers all day and at night there were two waking carers. The manager said extra staff would be provided when necessary. For example if a person in the home was unwell or needed to attend a hospital appointment. There was evidence on the day of the inspection that an extra member of staff took one person to hospital for an appointment and other staff confirmed this. Staff told us that holidays and sickness were covered by other staff working at the home. This was confirmed by the manager, who stated that there were no agency staff employed.

Staff we spoke with were able to tell us about how they would deal effectively with a person who displayed difficult behaviour. They commented that there were currently no people in the home who had serious challenging behaviour. One member of staff explained how they manage situations. For example, one person in the home can be reluctant to take medication and becomes agitated. They told us how they encouraged the person to take their medication by talking with them and sitting at their level, explaining what the medication is for and that although they don't have to take it they should think about it. The person usually agrees to take the medication. Another person does not like help with their personal care. The member of staff sings with them and as a result the person sings and continues, with assistance, to wash and dress.

While no applications had been submitted, proper policies and procedures were in place but none had been necessary. Staff had been trained by the local authority to understand when an application should be made, and in how to submit one. We found the location to be meeting the requirements of the Deprivation of Liberty Safeguards.

At our last inspection in February 2014, we found a number of issues with the way medicines were managed which meant that safe and effective arrangements were not in place to ensure that people were receiving their medicines as prescribed.

The provider wrote to us on 27 March 2014 stating that they had taken action and had made the necessary improvements by 07 February 2014.

At this inspection, we found a policy for medicines to be used "when required" or "PRN", and written guidance was now available to enable staff to administer these medicines correctly. Although most people were unable to manage their own medicines, one person was being supported to self-administer prescribed creams. A risk assessment had been written and secure storage had been provided in their room.

Although improvements had been made, we found that medicines audits had not been carried out by the manager

Are services safe?

in sufficient detail to ensure the safe administration of medication. The manager was aware that the audits were not comprehensive, but had not taken action to address this.

We found that the service did not always follow current and relevant professional guidance about the management of medicines. All prescribed medicines were available in the home but topical medicines, such as creams, were not being used as prescribed. We found prescribed creams in people's rooms which did not appear on their current medicine administration records (MAR). Some creams were overstocked, some were without labels or date of first opening, and for some prescribed creams there was no record of use. This meant there had been a breach of the relevant legal regulation (Regulation 13) and the action we have asked the provider to take can be found at the back of this report.

We saw that the full details of Controlled Drugs administered to people were not always recorded in the Controlled Drugs register. This meant people may not have received the prescribed medication required.

We noted that some staff had added handwritten medication details to people's printed MARs. We saw that no checks had been carried out to ensure that instructions for these medicines had been transcribed correctly. We also saw that staff had handwritten records when some medicines were changed or stopped. However, it was not possible to identify which member of staff had made these changes as the amendments were not always signed and dated. This meant there had been a breach of the relevant legal regulation (Regulation 13) and the action we have asked the

provider to take can be found at the back of this report.

We saw records of fridge temperatures that showed for a period from October 2013 medicines, which included insulin, had not been stored at the correct temperatures to remain fit for use. The manager told us that the insulin had not been administered to anyone as the person, who had been on respite care, had been taken into hospital; however other medication such as antibiotics had been stored in the fridge at that time.

Although staff had received half a day's medication training, the manager had not carried out any formal competency assessments before allowing staff to administer medicines to people. This put people at risk from staff who did not have the appropriate skills to manage medicines. This meant there had been a breach of the relevant legal regulation (Regulation 23) and the action we have asked the provider to take can be found at the back of this report.

Staff told us that there was no-one in the home that did not have capacity. The manager said that there was one person who may need an assessment under the Mental Capacity Act (MCA) in the future but the person was still able to make decisions at the moment. This meant people's capacity was considered under the MCA.

They said that all those people living in the home had families who acted on their behalf. The manager stated that there were three people whose family had Enduring Power of Attorney, but there was only one family that had provided a copy of the document. The provider may find it useful to note that the manager was not aware of other support agencies such as Age UK, Parkinson's Society and Independent Mental Capacity Advocates (IMCA) who could act on people's behalf, although staff told us that there was information available should anyone request an independent advocate and were able to offer examples of those services.

Are services effective?

(for example, treatment is effective)

Our findings

People's needs were assessed and their support and care was planned and delivered in line with their individual plans. Two relatives knew about, and had been involved in, writing the care plan for their family member. Information on three of the four care plans we looked at showed the person or their relative had been part of the process. This meant steps were taken to involve people and their relatives in making decisions about their needs. The manager stated that there was no available record in the new care planning system, which was now on computer, for people to sign they have been involved. We discussed other options to evidence the fact.

Staff we spoke with said they were able to meet the needs of the people living in the home. They were aware of people's care plans and the support each person needed. They told us they were not involved in writing the care plans but if they noted any changes in a person's health or wellbeing they knew who to speak to and ensured the plan was changed. This meant people's plans were kept up to date and staff had information that was current.

Examination of a sample of four people's care records showed that their health was maintained and promoted. People who used the service were supported to access a range of health care services. People we spoke with, and their relatives, told us they had input from a variety of health professionals including their general practitioner (GP), district nurse, dietician, chiropodist and hospital staff.

We looked at people's care records, and information provided by members of staff, indicated that people's weights were monitored and action was taken if needed. This included referrals to the dietician or GP where necessary. We saw that where a dietician had requested a person be weighed more frequently, this was done. This meant people's physical health and wellbeing were monitored and actions were taken if needed.

Most people we talked with were happy with the support they received at meal times. One relative said that her mother would probably like another drink in the afternoon whilst one person said they would like a fresh drink in the afternoon. This person was not happy with her meals and said: "The meals are always cold by the time they get up here". We observed staff during the day and heard them ask people if they wanted drinks or snacks. We fed back to the manager about the meals being cold when they arrived in one person's room and were told it would be dealt with. Minor improvements were needed so that people had fresh drinks available at all times.

We saw that people living in the home and their families had been encouraged to detail information to support their individual end of life wishes. The manager said that any equipment or extra staff would be provided when necessary. People living in the home did not have any concerns about staff training and made some complimentary comments about the staff. One

person said: "Yes, they all know what they are doing". The relative of a lady with complex physical disabilities said: "I think they deal very well with her". We looked at training records which showed staff had received appropriate training. Staff we spoke with told us about their training and that the majority of updated training was provided on the computer.

In discussions with people about whether staff understood and knew them, we found that people who were more able thought they were catered for quite well. One family member said about her relative: "They know what he likes and what he doesn't like, they look after him really well".

There were some people with dementia who were not engaged. We saw records that showed all staff had received training in caring for someone with dementia. The manager explained that the staff were in the process of compiling a, "This is my life" book for each resident living with dementia. Staff we spoke with said they would be completing the books with the person and their family as soon as possible and that it would provide a better understanding of the person. Minor improvements were needed so that all those who lived in the home were engaged.

We observed that people were supported with equipment to be independent, and this was done safely and with respect to people's dignity and privacy.

Are services caring?

Our findings

People we spoke with, and their relatives, told us they were very happy with the care they received in the home. One relative said: "Staff do a brilliant job". One person living in the home said: "It's lovely here. I couldn't wish for better." One relative said, "They're very polite, as soon as I got here the staff got me a cup of tea".

One person said the staff were: "…smashing". People we spoke with told us they were treated with respect and dignity by the staff. One person said, "Yes they always do" – referring to being treated with respect. One relative said: "I come regularly and have seen that people are being treated with respect". We heard people being addressed in the way they wish to be. One relative said: "He likes to be known as X and staff always speak to him using his name". Another person told us that when their relative visited the home, staff asked them where they would like to spend time. Most of the time the person chose to take their relative into their bedroom which they said showed a regard for their privacy and dignity. During the inspection we heard how people were asked their choice of meal, drinks and day to day preferences. Staff were able to tell us how they provided choice for people to ensure their independence was maintained as far as possible. This meant people were offered and given individual preferences.

Care and support was centred on each person. It was evident through our observations during the inspection that staff were caring and knowledgeable about each person and their individual ways of working with them. The staff responded and understood people and were able to meet people's needs. Staff were able to tell us how they communicated with people and that there were different methods available, such as pictorial information, should that be necessary. They all said that people in the home managed to convey their requirements verbally and by body language so have not had to use other methods.

Kindness, respect, dignity and compassion were evident in the incident that occurred during the inspection. Staff laid down on the floor with the person so as to be able to communicate with them. They used a screen to keep the person's dignity and respect. The staff ensured the person was comfortable using duvets, pillows and blankets until the paramedics arrived.

Information provided by the staff and in the paperwork available ensured that people had the necessary information with them to take to hospital. We saw that staff supported people for appointments to hospital and in emergency situations. One person confirmed that they were always accompanied by a member of staff for hospital appointments.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

There was evidence in the files of the three people we looked at, that they or their relative had been part of the planning of their care and that their choices and preferences had been taken into account. All the people we spoke with were happy with how staff communicated with them and responded to their caring needs.

One relative said: "They always say if we have any complaints, just say and they will be dealt with". All the people we talked with said they knew how to complain and would complain if they wished, but no-one had done so. There had been no formal complaints made in the home.

The manager explained that there was an activities co-ordinator who arranged activities for people

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One relative said: "They always say if we have any complaints, just say and they will be dealt with". All the people we talked with said they knew how to complain and would complain if they wished, but no-one had done so. There had been no formal complaints made in the home.

The manager explained that there was an activities co-ordinator who arranged activities for people living in the home; however they only came to the home once a week. Manicures were given as examples of activities for people. The co-ordinator also organised another person to come into the home to do a skittles activity. The people we spoke with mentioned that they were happy with these activities, or chose not to participate in the activities at all. Staff we spoke with said they understood the people who were living in the home and were able to meet their needs. They said that most people would tell staff if they were not happy participating in any activity, but would be offered all opportunities available. On the day of inspection we saw that there were no activities that took place. This meant there were no different types of activities to suit individual interests and needs, nor different methods to encourage or engage people with rewarding activities.

Staff said each shift was different and there were times when they would have liked to spend more time with individual people in the home. The manager said that staff did have the opportunity, once people have been assisted to get up, washed and dressed, to spend time with people. There were some people who needed assistance to eat their meals and the manager said staff were expected to ensure people were not isolated. The manager stated that there were five people in the home who chose, each day, to stay in their room. It was expected that staff would go in regularly to check people's welfare and we saw that staff went to people's rooms to take drinks and their meals. Staff we spoke with told us they visited people in their rooms to ensure they had drinks available and any meals if they wished to remain in their room. People we spoke with told us they were asked if they wished to go to the dining room for meals and to attend any activities.

Two people mentioned how quickly staff responded to people's emergency calls and requests for care. They emphasised that the staff were particularly good at this aspect of their caring role. One said: "They are there like a shot, they have done very well" and another said: "They're good at their job, when people ask for assistance they're soon there,…they are good".

Are services well-led?

Our findings

Laburnum Lodge has a registered manager in post.

We saw that the manager worked with the staff and was available to support them when they needed it. However we noted that the hours worked by the manager were not detailed on the rota which meant staff would not be aware of her availability. Staff we spoke with said the manager and provider were approachable and they would be able to question practice and would whistle blow when necessary, but they had not needed to do so. They said there was information, including telephone numbers, so that they could deal effectively with their concern.

The operations manager said there had been quality assurance questionnaires sent to people in the home, their relatives and professionals in August 2013. The information provided in the responses showed people wanted more areas in the home so that they could talk privately with family and friends. On the day of inspection this had not been completed. Following the inspection we received information from the operations manager that the general areas in the home had been changed and people and their families said the layout was much better. This demonstrated that although only minor changes had been necessary it had taken the provider seven months to complete.

We were told that there were no formal systems in place to monitor and assess the sufficient numbers of staff to ensure people's needs and levels of dependency could be met. This meant there had been a breach of the relevant legal regulation (Regulation 22) and the action we have asked the provider to take can be found at the back of this report.

The manager stated there were no residents or relatives meetings for people to express their views, or raise concerns on a regular basis, however, people had opportunities to speak with staff daily, and they in turn would refer any issues to her during daily handovers and staff meetings. Minor improvements were needed as there was no evidence that the meetings and handovers had taken place, nor what the outcomes were.

Governance and quality assurance systems were not effective because audits and checks were not completed adequately. This meant there had been a breach of the relevant legal regulation (Regulation 10) and the action we have asked the provider to take can be found at the back of this report.

Staff were able to tell us about their roles and responsibilities. Care staff were clear that only senior staff administered medication.

Notifications had been sent to the commission when necessary and had been completed adequately.

Staff told us about emergency situations such as a fire or other incidents. They told us there was information available such as the fire evacuation plan for each person in the home and the organisation of staff in the event of a fire.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010. Assessing and monitoring the quality of service provision. Audits and quality assurance monitoring were not completed or addressed to identify, assess and manage risks relating to the health and welfare of people in the home.

Regulated activity	Regulation
	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010. Management of medicines. People who use services and others were not protected against the risks associated with the unsafe use and management of medicines. This was because the registered person was not carrying out sufficiently detailed medicines audits, and therefore did not have an effective quality assurance system in place for medicines. The registered person did not have appropriate arrangements in place for the safe keeping of medication because medicines were not being stored at the correct temperature to remain fit for use.

Regulated activity	Regulation
	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010. Staffing The provider must take appropriate steps to safeguard the health, safety and welfare of people by using relevant guidance to ensure there are sufficient numbers of staff.

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010. Supporting workers

The provider must ensure that staff have received appropriate training in medication administration to enable them to deliver care to people living in the home.