Aegis Residential Care Homes Limited

Ladydale 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 31 May 2018 and was unannounced. Ladydale Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. It can accommodate up to 54 people in one adapted building, split into two floors with one unit on each floor. There were 43 people using the service at the time of our inspection.

At the previous five inspections we identified that improvements were needed to the quality of care and to governance systems in place to monitor care. This inspection was to check that improvements had been made. We found improvements had been made and sustained.

There was no registered manager in post. 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. The deputy was acting as the manager until a permanent manager who would apply to the CQC to become registered could be found.

People told us they felt safe and we saw that measures had been taken, such as risk assessment and staff following these to ensure people were kept safe. When things had gone wrong the service had learned and action was taken to reduce reoccurrences. Staff were recruited safely and there were sufficient amounts of staff to meet people's care needs.

People's medicines were managed safely. There were effective systems in place to ensure people had their oral medicines as prescribed and improvements were made to the documentation of topical medicines following feedback.

People were protected from the risk of infection. The building was appropriately maintained and plans were in plan to help people evacuate in the event of an emergency arising. The building was also appropriately adapted to cater for the needs of the people living there.

The service was working within the principles of the Mental Capacity Act 2005 (MCA) to ensure people's rights were protected. Decision-specific assessments were carried out with best interest decision being recorded and appropriate referrals were made to the Deprivation of Liberty Safeguards (DoLS) authority.

People enjoyed the food and had a choice of food and drinks which we saw staff catering for.

People were supported to access other health professionals where necessary and health professionals felt referrals were appropriate. The service carried out assessments to ensure they could effectively support people.

Staff had appropriate training and support to be able to care for people well.

People felt they were treated with dignity and respect. Where possible people were supported to retain their independence and make decisions about their care. Staff supported people in a way that suited the person.

Staff knew people well and plans reflected people's needs. People's diverse needs and end of life choices had been considered. Activities were arranged for people to partake in.

People and relatives were able to complain and feedback was acted upon and responded to, overall.

Effective systems were in place to help identify improvements required and taken was taken to resolve any concerns identified. Further improvements were planned with the introduction of an electronic system. People, relatives and staff felt the acting manager was approachable and they could feedback their opinions of care. Notifications were submitted to the CQC as required and the previous rating was being displayed.

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.

People and relatives told us the home felt safe.

People were protected from potential abuse by suitably recruited staff, who understood their responsibilities.

There was mixed feedback about staffing level but overall there were enough staff available to support people.

Medicines were managed safely and action taken when improvements were required.

Plans were in place and being followed to help keep people safe.

The service had learned when things had gone wrong to try to avoid incidents happening again.

Is the service effective?

Good

The principles of the Mental Capacity Act 2005 were being followed and staff offered choice and checked consent.

People enjoyed the food and drinks and were offered a choice.

People were supported to access support from other health professionals.

Assessments were carried out to determine if people's needs could be met and this was reviewed and health monitored.

Staff were trained and felt supported to care for people effectively.

The building was appropriately adapted to meet the needs of people living there.

Is the service caring?

Good

The service was caring.

People were treated them with kindness and respect by staff.

People were supported to maintain their dignity and independence.

People could make decisions about their care and were offered choices.

Is the service responsive?

Good

The service was responsive.

Staff knew people well and care plans contained personalised information.

People's communication and diverse needs were taken into consideration.

People were supported to plan for the end of their life if they chose to.

People and relatives could complain and they were responded to.

Is the service well-led?

Good

The service was well led.

Systems were in place to assess, monitor and make improvements to the quality of care people were receiving.

People, relatives and staff felt the acting manager was approachable.

People, relatives and staff were asked for their feedback.

Ladydale 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 inspection took place on 31 May 2018 and was unannounced. The inspection was carried out by two inspectors.

We looked at information we held about the service including statutory notifications submitted. Statutory notifications include information about important events which the provider is required to send us by law. We also asked commissioners and Healthwatch if they had any information they wanted to share with us about the service. Healthwatch is an organisation that gathers information from people and relatives who use services and provides feedback to commissioners and regulators (like the CQC) about those services. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with six people who used the service, five relatives, seven members of staff that supported people and two professionals that have contact with the people who use the service. We spoke with the area manager from the provider and the acting manager. We also made observations in communal areas. We reviewed the care plans for four people who use the service, as well as medicine records for some people and looked at management records such as quality audits. We looked at recruitment files and training records for three members of staff.

Good

Is the service safe?

Our findings

At the last inspection the key question of, 'Is the service safe?' was rated as Good. At this inspection the evidence showed that it continued to be Good.

People told us they felt safe and relatives confirmed this. One person said, "Yes I feel safe, I have people around me, there are smoke alarms and I have my buzzer." A relative said, "Yes it's safe. My relative can call for help when they need to." Another relative said, "Yes my relative is safe. It's the surroundings and how the staff are [with my relative] and they are attentive." People were protected from potential abuse by staff who knew about the different types of abuse, signs to look for and their responsibilities if they thought someone was being abused. We saw that appropriate referrals had been made to the local safeguarding authority as required and a suitable policy was in place. The service also followed safe recruitment practices. Staff files we viewed included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with people who used the service. This meant that people were supported by staff who were suitable to work with the people who used the service.

There was mixed feedback about staffing however overall there was a sufficient amount of staff available to support people. One person said, "If they're busy it can take them a very long time to come." A relative said, "There is not enough staff." There were also positive comments about staffing. One relative said, "There always seems to be staff around." A staff member said, "Yes there is enough staff. It has improved and we do feedback." Another member of staff said, "If there wasn't [enough staff] I wouldn't work here." A health professional we received feedback from said, "I have not experienced staffing levels as a concern and a member of staff has always been available to shadow me, and assist if required." We saw care staff were available in communal areas and on each floor of the home. The acting manager explained and we saw that there was a dependency tool they used to help decide how many staff were required and staffing was due to increase.

Risks to people were assessed and planned for to help keep people safe. One person said, "I'd had three falls at home. I chose to have the hoist, it's safer for me." A relative said, "My relative has not had any falls." Another relative said, "They [staff] help manage my relative's falls. They walk with a three-wheeled trolley." One person was at risk of developing pressure sores. They told us, "I'm on a propad cushion and a propad mattress." Propad is a specialist soft cushion to help relieve the pressure on people's skin when they are sitting or lying down. We saw other people other people had plans in place to help support them to maintain their skin integrity.

In another example, one person had a risk assessment carried out in relation to having bed rails to stop them falling out of bed. The assessment identified that the risk of the person becoming trapped was too high so the bed rails were removed and alternative measures were taken to keep the person safe. We observed people being appropriately supported to move and we saw that equipment, such as hoists, wheelchairs with footplates, walking frames and stand aids were available for people to use. People had plans in place about how they needed to be supported by staff to move. Some people experienced periods

of anxiety and agitation. We saw that plans were in place to help staff identify what may cause a person to become anxious and what they can do to support the person. We also observed staff support people which helped to calm them.

The service had learned lessons when things had gone wrong. Accidents and incidents were recorded, these were analysed to help identify any trends and action was taken to reduce the likelihood of a similar incident occurring again.

People told us they had their medicines and we saw medicines were being managed safely. One person said, "They put creams on my bottom to stop me getting sore and I'm not sore now." Another person said, "I get tablets every morning." A relative said, "She gets her blood pressure tablets. It's better than when she was at home." A member of staff involved in administering medicines told us, "They [other staff] leave me and give me enough time to do the medicines." Another member of staff told us, "We have a good relationship with the pharmacist." We saw that it was recorded when people had their medicines. Stock levels were recorded and we saw that the amount of stock matched records. Medicines that should only be used for a certain amount of time after they had been opened all had an 'opened' date on and they were all still suitable to use. This meant people were supported to have their oral medicines as prescribed.

The service had recently changed to an electronic 'app' to record when topical creams and lotions had been applied. Although this allowed accurate, real time documentation but it did not include protocols or name the actual cream or lotion. A member of staff said they typed in the name of the actual cream they applied but previously they had used to use paper charts. We brought this to the attention of the area manager and paper topical medication administration recording was re-introduced the same day. The acting manager said they will continue using the paper documents until the software is refined to include more detailed information.

We saw that the temperature of the rooms that medicines were stored in was regularly checked. There had been occasions when the temperature had been over the recommended maximum. When this was feedback to the acting manager, they immediately sought advice from their pharmacist which confirmed the medicines were safe to use. Immediate action was also taken to reduce the temperature. Following our visit, we received evidence that the concerns had been resolved. Controlled drugs (CDs) are prescribed medicines that are often used to treat severe pain and they have additional safety precautions and requirements. CDs were stored, administered and recorded in a way that met the legal requirements.

People were protected from the risk of infection. Staff told us there were always plenty of aprons and gloves when they needed them. We observed staff wearing blue plastic aprons to serve food. The home was clean and tidy. Bathrooms and toilets were all equipped with soap in dispensers, paper towels and bins with foot pedal opening. Staff had received infection control training and audits were carried out by an external company to check whether the home was compliant. Where improvements were required an action plan was put in place to resolve any concerns.

There were Personal Emergency Evacuation Plans (PEEPs) which identified how people should be supported to leave the building in the event of an emergency. People were also protected as the building was being appropriately maintained. For example, necessary checks were carried out on the electrical systems, fire systems and equipment, lifts and equipment were serviced and water services were monitored appropriately.

Good

Is the service effective?

Our findings

At our last five inspections, we found that improvements were required to ensure the service was complying with the requirements of the Mental Capacity Act 2005 (MCA). At this inspection we found improvements had been made and people were supported appropriately.

The MCA 2005 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. We saw that appropriate assessments of people's capacity had been undertaken in relation to specific decisions. If an assessment had resulted in it being determined a person did not have capacity then a best interest decision was considered and recorded. 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 saw that appropriate applications had been made following an assessment of a person's capacity. A person who has Lasting Power Of Attorney (LPOA) for health and welfare has the legal right to make decisions and sign agreement on behalf of someone who has lost their capacity to make their own decisions. We saw evidence that LPOA had been considered and saw some evidence of LPOAs in people's files.

People and relatives told us they were offered choices and we saw staff offering choices and checking consent. One person told us, "It's my choice to go to bed early." Another person said, "I get up when I want." We observed staff asking people where they would like to sit, what food and drink they would like and people's choices were respected. This meant the principles of the MCA were being met to protect people's rights.

People enjoyed the food and had a choice in what they had to eat and drink. One person said, "I like the food, they offer me a choice; I've put weight on!" Another person said, "Yes, I get a choice, I like all of the food here." A relative said, "My relative likes the food and they get to choose. I've had a meal here too as they've offered." Another relative said, "My relative likes the food, they have good menus on. They [relative] always likes the same thing for tea." We observed staff giving people the choice of what to have for breakfast and lunch and people's choices were catered for. We saw records that people's fluid intake was being monitored when necessary to ensure they were having sufficient amounts. Appropriate guidance was in place for those who were assessed as needing a modified diet to keep them safe.

People were supported to access health professionals when necessary. One person said, "I've had my tablets changed as I had hallucinations. The GP came and stopped the tablets and within a day I was better. They [the staff] were on it [very quickly." Another person told us, "The physio has been and I do exercises." A relative said, "The staff knew before me that my relative was ill." Another relative said, "They ring me if my relative's health changes and I can feedback to senior staff." We saw evidence that people had seen other professionals, such a speech and language therapists (SALT), opticians, physiotherapists, continence nurses, district nurses and community psychiatric nurses. One health professional we received feedback from said,

"The staff have always responded well when I have highlighted minor issues in the past and appeared grateful for the support" and they went on to say, "The majority of referrals I have received have been appropriate and through the correct pathway." Another health professional told us staff acted on any advice they gave and they had, "No concerns about care."

The service carried out a pre-admission assessment prior to a person moving to the home to check whether they could support a person's needs. Staff we spoke with said they always read the care plans so they knew about people's risks and care needs. One staff member said, "If someone new comes in, we are given all the information we need, and we fight over [reading] the care plans!" We saw that there was ongoing monitoring of people's needs through reviews of plans and monitoring of their health conditions or concerns. This included ensuring people did not lose weight unintentionally and if a person had a fall, the service used a form for staff to document frequent observations over the subsequent 24 hours. This was best practice which helps identify injuries not immediately apparent and complications that might develop hours after a fall.

Staff told us and we saw that they had appropriate training to support people effectively. One member of staff said the training, "Prepared me to work here." There was a mixture of face to face learning and online courses. Staff had access to training on an app they could install on their phone so they could access it at a time convenient for them. A new member of staff said, "They've given me an app for my phone so I can do my training as soon as possible" and they went on to say, "I've been shadowing and watching how to use a sling." The area manager could monitor staff training and compliance via the same app so they could see if any staff were overdue on completing their training. Recorded were maintained to track how many staff needed their training updated. Staff also told us they felt supported. One staff member said, "I feel supported, we've got a good gang [of staff]. The seniors support you to get to know what's going on." This meant people were supported by suitably trained and supported staff.

The home was suitably adapted to cater for the people living there. The bathrooms were adapted for easy access and equipment was available for people to use. We saw that bedrooms had people's names on to help people identify their own rooms and bedrooms were personalised with people's own items, such as photos. There were well-maintained, secure garden areas and seating to which people had access and further improvements were planned to these areas.

Good

Is the service caring?

Our findings

At the last inspection we found people received support in a dignified way. At this inspection we continued to find that people were supported appropriately.

People and relatives told us staff were kind, caring and treated people with respect. One person said, "The staff are marvellous; I'm incontinent and they help me. They're friendly." Other comments from people included, "The staff are very nice" and, "I'm happy with the staff." A relative said, "The staff do their best." Another relative said, "I genuinely feel my relative gets a lot of care and all staff are amiable" and they went on to say, "The staff show a lot of care on a personal level." Another relative commented, Staff make the residents feel at home." A visiting health professional told us, "The residents seem happy" and said they often saw staff singing with people. We observed people and staff enjoying one another's company. One person said to a staff member, "We're always happy with you." We observed a staff member supporting a person to eat. The staff member did not rush the person and they were having a little chat rather than sitting in silence.

People were offered choices, could make decisions about their care and staff knew people well. A visiting health professional said, "Staff seem to interact with and know people well; they seem caring." For example, we observed staff asking people if they wanted to wear a protective apron over their clothes whilst they ate. Some people wanted one and others declined. We saw staff respecting those people's choices. We observed two staff members administering medicines and they did so in a way that showed they knew people well. They were patient and allowed people to take their medicines in their own time, without rushing them. People were supported in different ways to take their medicines.

People were supported to maintain their dignity and remain independent where possible. One member of staff said, "Let people do everything they can do for themselves, you can't take that away from people." Another staff member told us, "I allow people to do as much for themselves as they possibly can, and encourage them." Another staff member said they, "gently reminded" people to do things. All staff we spoke with were able to give examples about the ways they would ensure someone maintained their dignity, such as keeping people covered and keeping curtains and doors closed during personal care. Bedroom doors had signs with pictures chosen by people of something they liked, such as boats, or flowers. On the reverse the signs said 'carer' and staff explained this was turned if staff were in the room delivering personal care.

People's care records were in held in paper files and a recently introduced electronic system. Paper files were stored in a locked room. The electronic system was password protected to ensure information was secure and all care staff had access to it from computer terminals and handheld electronic devices.

Good

Is the service responsive?

Our findings

At the last inspection we found improvements were needed about the quality of information held in people's care records. At this inspection we found improvements had been made.

Staff knew people well and people's plans contained good personal detail to help staff support people in an individualised way. One person said, "I couldn't look after myself and I've got a lot of friends here, this is my home." One relative said, "I've found the staff to be very good." When we spoke with staff we asked them about people's needs and we compared what they told us to people's care plans. What staff told us matched people's care plans. Details in plans included how people liked to be cared for when having personal care and getting dressed. For example, what support a person may need to choose clothes, when they preferred to be supported – one person preferred to be supported at night for a bath – the type of toiletries to use and the gender of the staff supporting them. We saw that plans were reviewed regularly and changes made when necessary to ensure they remained up to date.

The service had considered how to support people with a range of protected characteristics. Characteristics include gender, religion, sexuality and race. Staff said ministers of religion attended the home and held services for Roman Catholics and Church of England. A carer told us they had changed the way they invited people to attend the regular religious services held in the home after realising, "Some people are offended if asked in a jolly way." Staff also received training in equality and diversity. People's communication needs were also taken into consideration. We saw plans were in place which described people's communication needs, for example if they required glasses or a hearing aid. One member of staff told us about a person who could communicate decisions by nodding their head, they said they had to, "Look at the person's face very closely." Another member of staff described how they supported people to make decisions by rephrasing a question or using visual props, such as a cup of tea. They said watching people's faces helped them know if the person understood but was not able to communicate verbally. This meant people were supported to communicate in a way that suited them.

People were supported to partake in activities. One person said, "There's enough to keep me occupied." A relative said, "There's been a garden party and entertainment" and they went on to say, "People get taken out for tea or the pub." We observed staff interact with people throughout the day and they were kind and pleasant. We saw staff sitting and talking to people about topics that appeared to interest them. We saw that entertainment and other ideas were discussed as resident's meetings. A person had also been able to bring their pet with them who had become popular with people living there and a risk assessment was in place for this.

People had the opportunity to discuss their end of life choices and how they would like to be cared for. One person told us, "I don't want resuscitating. I had a doctor visit me." A relative said, "We've had an interesting talk about end of life. The doctor has been to explain and they involved my relative. We talked about the funeral and that my relative wants to remain here [in the home]." One person had become unwell and may have been nearing the end of their life whilst we were visiting the home. During a handover a member of staff was designated to ensure the person was comfortable and checked on regularly. We saw plans were in

place for people who had chosen to discuss their end of life wishes which included who to contact, the clothes they would like to be wearing and whether they wanted resuscitating or not.

People and relatives told us they felt able to complain and complaints were responded to. A relative said, "I did complain about something and I think it would be sorted again." Another relative said, "I feel able to raise concerns." One relative made us aware of a complaint they had made which had not yet been resolved. When we spoke with the acting manager about this they were still in the process of responding. We also saw when other complaints had been made they were recorded, action taken and responded to appropriately. There was also an appropriate policy was also in place. This meant the service listened to feedback and tried to improve people's experience of care.

Good

Is the service well-led?

Our findings

At our last five inspections, we found that effective systems were not in place to assess, monitor and improve quality and manage risks to people's health and wellbeing. At this inspection, we found improvements had been made and sustained and the service was now rated as good.

The home did not have a registered manager in post. The deputy manager was acting as the manager until a permanent manager who applied to the CQC could be found and we saw that recruitment had been ongoing.

We saw audit systems were in place which had been effective at identifying and rectifying concerns. We saw that accidents and incidents were analysed for trends to try to reduce the likelihood of them reoccurring. Regular observations took place to monitor the service, such as looking at people's dining experience, cleanliness and medicines administration. Other aspects of people's care were also audited, such as people's weights to ensure that if anyone had lost weight the appropriate action had been taken. We also saw that if someone had maintained a steady weight for a period then the frequency they would be weighted was reduced. Trends in relation to safeguarding and complaints were also checked. An audit into safeguarding had identified medicines issues had been a theme. Action had been taken to try and prevent further issues and medicines audits had been carried out. If a medicine error had occurred, we could see it had been recorded and action taken to protect the person. In addition to frequent audits by the acting manager there were also reviews carried out by the area manager to ensure issues were being identified and dealt with. For example, one audit identified that some weight audits had not been done properly and a medicines audit had not been completed. We saw that the medicines audits had been carried out since and steps were introduced to ensure weights were reviewed correctly. Another audit picked up that two notifications had not been submitted to the CQC which are required by law. Following this they were submitted and other notifications had continued to be submitted. The previous rating was also clearly displayed in a communal area and on the website as required. Systems were in place to monitor and help to determine the staffing levels. It considered the number and dependency levels of people living there, as well as the building. The acting manager explained to us, "We use a dependency tool and we consider the geography of the building too." This meant effective systems were in place to monitor the quality of care and resolve any improvements identified to help keep people safe and in a caring environment.

A new electronic system had been introduced and staff had a mobile device with people's detail on and staff could record how they had supported people. Staff were complimentary of the new system. One staff member said, "The system is quicker and it gives us more time with the residents. There's enough information and we can be among residents." Another member of staff told us, "Online is absolutely brilliant, it's got everything at hand and quick to get. It speeds things up and is better for the residents. It's good for monitoring care staff too as we can see what needs to be done." The electronic system allowed data, such as people's weight or blood sugar level to be shown in graphs helping staff see improvement or deterioration. A staff member told us that a dietician had asked for someone's weigh recently and they had used the app: "It's brilliant, you just go in and see [the information] right away." The area manager said, "The electronic system will be excellent for audit and knowing what's getting done" and they went on to say,

"There's nowhere to hide with an electronic system." There were future improvements planned so that people and relatives could have access to the electronic system, for their own records. This meant the provider was taking steps to change and improve how the service was monitored and to ensure people were getting the care and support necessary.

People, relatives and staff felt the acting manager was approachable and also felt the service had improved. One relative said, "Since [the previous registered manager] it has improved 200%. The deputy [acting as the manager] chats to me." A relative told us, "The [acting] manager is brilliant." A new member of staff said, "I love it… everyone is lovely; I've never worked with such lovely people." Another staff member commented, "The [acting] manager is approachable." Senior staff gave the impression they were keen to improve and welcomed our visit and responded to any queries we raised positively. People, relatives and staff told us they were asked for their opinion about the care. One person told us about meetings they could attend and questionnaires and we saw the minutes of resident's meetings. Relative's also told us about questionnaires they received. One relative also said, "There are relatives meeting but I don't always go." A member of staff said, "We have meetings and it gives us chance to find out what's going on and can feedback." We also saw the minutes of staff meetings which had been taking place; for example, one discussed the introduction of a key worker system whereby staff would be responsible for the plans for particular people. Staff knew about whistleblowing procedures as they had been informed by the home. One member of staff said, "I can get a job somewhere else, they've [people living in the home] only got one life here." This meant the home encouraged feedback and staff understood the importance of them raising concerns. This meant the service was proactive in seeking feedback and trying to improve people's experience of care.