Cadmore Lodge Limited

Cadmore Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection was undertaken on 12 January 2017 and was unannounced.

The provider of Cadmore Lodge is registered to provide accommodation nursing and personal care for up to 14 people. At the time of this inspection 6 people lived at the home. Bedrooms, bathrooms and toilets are situated over two floors with stairs and passenger lift access to the upper floors. People have use of communal areas including lounges, and dining rooms.

There was a registered manager in post who was supported by a Clinical Nurse Lead. 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.

Improvements were required to ensure people's medicines were stored and managed safely. People's medicines were not always stored at the recommended manufacturer's temperature. There was no guidance for staff to follow when people should be offered their as required medicines (PRN). The provider and registered manager had failed to operate proper and safe medicines management processes in relation to the administration, storage and recording of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not support this practice. Related assessments and decisions had not been taken. Continuous supervision and control, combined with lack of freedom to leave, indicated a deprivation of liberty, and the provider had not applied for this to be authorised under DoLS.

People had access to a choice of foods and drinks. However kitchen staff were not fully aware of people's individual dietary needs and preferences.

Risks to people's health and welfare had been assessed although information in people's care plans and risk assessments did not always provide an accurate reflection of people's requirements.

People told us that staff were caring and respectful. Staff ensured that people's privacy and dignity was always maintained. People were spoken to in a kind and polite manner. People were able to choose how they wished to spend their time. People expressed their opinion that the amount of activities on offer did not meet their expectations and could be improved.

People were not always consulted about the care and support that was individual or personal to them to inform their care plans and risk assessments.

People had not been facilitated to provide feedback on their experience of the service to monitor the quality of service provided.

The provider had systems in place to assess and monitor the quality of the service provided but these in the process of being introduced and were not always effective in identifying shortfalls.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

This service is not safe

People's medicines were not safely stored.

People were not protected from the risk of harm as control measures and guidance for staff in managing risks were not in place.

Staff were able to identify and knew how to report signs of abuse.

Is the service effective?

Requires Improvement

This service is not effective.

It was not always clear that full consideration to MCA guidance had been adhered to where people were unable to make decisions.

People had access to a choice of foods. However kitchen staff were not fully aware of people's individual dietary needs and preferences.

Is the service caring?

Good

This service is caring.

Staff supported people in a caring way and respected their privacy.

People were supported to maintain contact with family members and others who were important to them

Is the service responsive?

Requires Improvement

This service is not responsive.

The contents of people's care plans varied. Not all care plans contained details of people's lifestyle and preferences.

People told us there were not enough activities offered.

People were aware of the provider's complaints policy and procedure.

Is the service well-led?

Requires Improvement

This service is not well-led.

The registered manager had failed to introduce quality assurance audits so they could not be used to ensure continuous improvement.

People had not been given the opportunity to provide feedback on the service provided.

Cadmore Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 12 January 2017 and was unannounced. The inspection team consisted of one inspector and a Specialist Advisor in nursing and older people's care.

We looked at information we held about the provider and the services at the home. This included statutory notifications. Statutory notifications include important events and occurrences which the provider is required to send to us by law.

We requested information about the home from the local authority, Clinical Commissioning Group (CCG) and Healthwatch. The local authority and Clinical Commissioning Group (CCG) had responsibility for funding some people who used the service and monitoring its quality. Healthwatch is an independent consumer champion, which promotes the views and experiences of people who use health and social care.

During our inspection we spoke with six people who lived at the home and used different methods to gather experiences of what it was like to live at the home. We observed care and used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spoke with two relatives of people living at the home during the inspection. We also spoke to a healthcare professional who was visiting the home.

We spoke to the managing director, the operational quality and compliance manager, the registered manager, the clinical nurse lead, agency registered nurse, two care staff, the chef and the estates manager. We looked at records relating to the management of the service such as, care plans for four people, the incident and accident records, medicine management and four staff recruitment files, training records, service review notes and residents meeting records.

Requires Improvement

Is the service safe?

Our findings

We looked at how the provider managed and stored people's medicines and found a number of concerns. When we checked the stock levels of medicines, we found they were not always accurately completed, for example a person that had come to live at the home the previous day, had their stock balance of their medicine incorrectly recorded. This was brought to the attention of the registered manager and that their medicines were not being stored in a medicines fridge, but in a domestic fridge. They told us this would be rectified, and the medicines would be moved to the medicines fridge.

We found some medicines were not being stored or disposed of correctly. For example the temperatures of the medicine fridge were not recorded and acted upon when outside of the recommended range. We brought this to the attention of the registered manager who told us they would contact the pharmacy immediately to check if the medicines were still safe for people to use.

Where people needed as required medicines (PRN) there were no guidance or protocols in place as guidance for staff to understand when and what circumstances the medicines should be administered. Therefore the provider could not assure themselves people received their medicines consistently and safely.

We saw medicines classified as controlled drugs were not stored correctly. Controlled drugs are drugs which by their nature require special storage and recording. We brought this to the attention of the managing director, who assured us immediate action would be taken, so the controlled drug cabinet could ensure safe storage.

We found prescribed creams and medicated lotions had been delegated to the responsibility of care staff, however the records of the administration of these creams or lotions were not clear and did not comply with the prescribing frequency. We saw there were occasions when both nursing staff and care staff were administering the same creams for one person. Another person had a cream in their room that was not currently prescribed. The cream had no prescribing label on it, and no date of opening yet care staff were still applying this cream to the person's skin. It was therefore impossible to determine whether prescription items were in use beyond their safe retention periods.

We saw a person was prescribed a variety of medicines that were inhaled via a nebuliser mask and on the day of the inspection the mask was observed as visibly dirty. The nurse on duty was unaware of when the mask should be changed or washed and there was no plan of care in relation to this in the person's care plan.

The provider and registered manager had failed to operate proper and safe medicines management processes in relation to the administration, storage and recording of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw bed rail padding protectors were not in use to safeguard people from the risks of injury and entanglement. The provider had not taken appropriate measures to safeguard people from the potential

risk of entrapment or injury associated with the use of bed rails. The provider did not have a bed rails policy for staff to refer to, and there was no risk assessment in place for the two people who used bed rails. There was no evidence that an assessment had been undertaken regarding the use of bed rails, or how people's consent had been sought. We brought this to the attention of the registered manager, managing director and compliance and operations manager who told us action would be taken.

People we spoke with told us they felt safe living at the home. One person told us, "I do feel very safe here as the staff are very helpful." Another person told us, "Yes I do feel safe here; the staff help me get up."

We spoke with staff about how they made sure the people they provided support for were safe. Staff told us, they received training in safeguarding people from abuse. Staff we spoke with were understood how to identify potential safeguarding concerns and how to report any concerns. The registered manager understood their role in reporting and protecting the people who used the service.

People's needs had been assessed before they moved into the home to make sure their needs could be met. However when we looked at the provider's risk assessments we found they had been completed but did not always reflect the abilities or needs of the person accurately and were therefore not able to inform care delivery. For example two people who both used aids for their mobility were documented in their moving and handling assessments as independent. They failed to inform staff, two people may require assistance and without their mobility aids were at risk of falls. We could not see the provider had involved people in their risk assessments.

The registered manager told us they calculated the number of nursing and care staff required based on an assessment of people's needs. The registered manager told us as the service grew, then it was planned to employ more staff. The registered manager said they were in the process of recruiting more staff, but in the interim the provider was using a high number of agency nursing staff. We saw a documented induction and the agency nurse on duty confirmed, it was completed for new agency staff before they started work in the home. We saw on the day of our inspection that call bells were answered promptly. One person told us, "If I call for help staff do come quickly."

Staff recruitment files showed that staff employed at the service had been subject to pre-employment checks. These helped to ensure staff were suitable to work with people using the service. However some staff had been employed with only one reference despite the provider's recruitment policy which states two references were required. The provider had made checks with the Disclosure and Barring Service (DBS). The DBS is a national service that keeps records of criminal convictions. The provider used this information to ensure that suitable people were employed, so people who lived at the home were not placed at risk through recruitment practices for nurses, the provider had checked their registration with the Nursing and Midwifery Council (NMC) was valid. Following our inspection the registered manager sent us confirmation that a recruitment audit had taken place and any missing references had been applied for.

People had personal emergency evacuation plans (PEEP's) in place to help them. PEEP's provide details on what equipment or assistance people would need to help them evacuate the building, should they need to. When we spoke to staff about these plans, they were aware of what to do in an emergency.

We spoke with the estates manager who showed us the records of checks on equipment were completed regularly to ensure people were kept safe.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager had not consistently applied the Mental Capacity Act 2005 (MCA). The assessments of people's capacity to consent and records of decisions had not been completed. Staff had not considered the legal process they needed to follow when considering a decision where a person had not had the capacity. We saw a person had bed rails in place, to help keep them safe during the night. However we could not see this had been discussed with the person or a MCA assessment and consent form had not been completed, which is not in line with MCA guidance.

One person told us, "I am not able to go for a walk by themselves without staff. They are worried about me falling. I've told them if I fall I'll shout. I had to wait an hour before staff were free to take me. " We could not find any MCA assessment or application of DoL authorisation to legally restrict the person's movements. This meant we could not be sure that decisions taken around supporting people's health and care needs were taken in line with MCA guidance, because records did not reflect this. We discussed this person's comments with the registered manager who acknowledged the person had to wait for their walk on the morning because staff were busy assisting other people. Following our inspection the provider sent us confirmation the capacity assessment and reviewed care plans were put in place for the people concerned.

Staff received regular training updates in relevant training topics. We looked at the service's training records and saw staff training was largely up-to-date although some updates were overdue. Staff received regular supervision and appraisal where they had the opportunity to discuss any concerns and their work practice was evaluated. The registered manager told us, "Through supervision I hope to identify continuous improvement and consistency in staff." Staff told us, they felt the registered manager was approachable and would listen to concerns.

People we spoke with told us about the quality of the food served at the home. One person said, "The food here is good but nothing elaborate." Another person told us, they thought the food was "Marvellous, if you don't like what is on the menu the chef will do you a steak."

We spoke to the chef on duty about how they are kept aware of people's dietary needs. Although they took

time to speak to people about their individual preferences, we found there to not be any written system in place to record and ensure the catering team were aware of people's dietary preferences, special diets or allergies. Two people's care plans referred to the need for fortification of their diets as they were at risk of malnutrition, yet when we spoke with the chef they were not aware of the needs of these two people and described them as both having regular diets.

People told us, they could ask for drinks whenever they wanted. One person said, "If we want a drink we just go to the bar and ask." Snacks were not freely available in the home for people to help themselves.

We saw people's initial assessments and care plans were not detailed to inform care staff of the care needed. For example, the assessment on admission did not document peoples' oral health needs, hearing, vision or continence needs. One person who had not had an oral health assessment completed, or a plan of care documented relating to their oral care had lost a tooth five nights previously and it was documented in the notes that they were finding it difficult to eat as a result. A person told us," I have asked if they have contacted the dentist but they haven't come back to me." Although the entry requested that they wanted to be referred to the dentist, there was no evidence that this had been followed up. When we discussed this with the register manager they were unaware of the situation but told us they would ensure the matter would be resolved promptly.

One person was unwell on the day of the inspection and staff had acted appropriately in monitoring the person's condition and requesting a visit from the person's doctor. The doctor visited on the day of the inspection and prescribed medication for the infection. On the day of our inspection we spoke with a visiting health professional they told us, they thought the staff that care for people were "Very good, and very caring."

Good

Is the service caring?

Our findings

We asked people if they felt the staff were caring, we received the following comments; "Oh yes the staff are marvellous, very caring." Another person described the staff as, "Very nice and very kind." A relative told us, they were "Always welcomed when they visited the home and offered refreshments."

There were a number of rooms, in addition to people's individual rooms, where people could meet with friends and relatives in private if they wished. People told us they could have relatives and or friends visit whenever they liked. We found the home to be furnished to a very high standard and very clean.

We spent time in the communal areas to see how people were cared for. We saw staff approached people in a respectful, patient and friendly manner. Care staff took time to speak with people as they were passing and we noted several conversations between people and staff about their family visits out that had occurred recently. We saw the housekeeper chat to people whilst they performed their duties.

People were given choices and involved in decisions about their care. One person said, "Oh yes I get up when I like and go to bed when I like." Another person said, "If you want anything you only have to ask and they get it for you".

We saw staff used people's preferred names and people were relaxed in the company of staff. Staff knew about people's preferences, likes, dislikes and interests. Some people and their families had shared information about their life history with staff to help staff get to know them.

We saw people had been supported to maintain their appearance because we saw staff had assisted people to access hairdressers and their clothing was of their choosing. One person introduced us to their hairdresser who had been invited into the home at their request and was able to use the designated hairdressing facilities on site.

People were encouraged to be as independent as they could be. We saw staff assisted people with mobility difficulties move into the dining room. They walked by the side of people and gently encouraged them whilst they used their walking aids to give reassurance. At lunchtime we saw that people were offered support from the staff when they needed it. We saw one person request "Please can you get me my grapes from my room." The care staff responded, "Of course I will." They went straight to the person's room and fulfilled their request.

Staff knocked on people's doors and before they entered when they checked whether people needed anything. We saw that people were treated with dignity and staff had a good understanding of what dignity meant for people. One person told us, "They always make sure my bedroom door is closed before they help me get dressed."

People's care plans and associated risk assessments were stored securely and locked away. This made sure that information was kept confidential.

End of life care was provided at the service. We saw people's wishes and preferences had been considered and recorded for all staff to follow. Staff were sensitive to these needs and they worked alongside external health care professionals. District and palliative care nurses were available to support staff to provide end of life care for people. One health professional visiting the home on the day of our inspection described staff employed at the home as "Very good, very professional and very caring."

Requires Improvement

Is the service responsive?

Our findings

People we spoke with told us the staff tried to be responsive to their needs but care staff were busy, so focused on care tasks. One person said, "There was not enough to do in the care home the only activity that had been put on by the home was a trip to the pantomime before Christmas." The person referred to the brochure for the home as "Misleading", as they felt the description of activities provided did not match the reality they experienced living in the home. We checked the provider's 'welcome book' given to people when they first came to live at the home. It suggested that activities offered included exercise and fitness classes, use of a heated swimming pool and stated, "Many interesting and varied hobbies and past times to suit our resident's individual requirements along with one to one person centres and meaningful activities". Another person we spoke with stated, "There was not enough to do in the home for people".

Another person told us, "It suits me to be quiet, but if you want to be kept busy, this isn't the place for you." A relative told us, "I feel they could do more with [relative's name] for example they enjoy playing dominoes". On the day of our inspection we did not see any organised activities for people. People sat in the communal lounge either chatting to each other or asleep. When we asked the registered manager about activities available we were told, "The swimming pool is not available for people to use yet because it needs safety equipment to be provided. We do tell people it's not part of our registered activities."

There were not enough activities in place to stimulate people, staff were engaged in care tasks and had little time to provide activities for people. When we discussed our findings with the registered manager they told us as the service grew they hoped to offer more opportunities for people. They told us, they wanted to be part of the local community so offered local residents to use the golf course on site and a weekly bridge afternoon onsite. They told how for one person they had arranged to attend a "bridge club" offsite supported by their family.

When we asked people and their relatives about their care plans, they told us they had not been invited to take part in reviewing and updating their care plans to make sure their views were included and ensure they received the care and support they wanted. One person told us, "No I haven't, they spoke with my relative." One relative told us, "Staff are nice but they don't listen to us [person's name] when they came to stay we provided written guidance. However the chef gives them ice cream which although they like it is not good for them, it sends their blood sugars too high." We brought this information to the attention of the registered manager and they told us they would investigate further to help prevent a further occurrence. In future people would be more involved in their care planning and reviewing process.

People knew how to raise a concern or make a complaint. One person said, "If I wasn't happy with anything I'd tell [staff name]." People told us, they would talk to the manager or clinical lead nurse if they wanted to make a complaint, but they stated they had never had to. We saw the provider had a system for recording and responding to complaints. We were told no complaints had been received since opening of the home.

Requires Improvement

Is the service well-led?

Our findings

A registered manager was in place and was supported by a lead clinical nurse. We found the provider had systems to assess, monitor and improve the service were in place but had not been completed. The registered manager told us, "This is work in progress. I am aware of the provider's quality assurance systems but haven't introduced them to the home yet."

We saw a lack of auditing systems had not identified issues in relation to care planning, risk assessments, care reviews, MCA, changes to health and care needs, recruitments and activities for people. As the registered manager was new to her role, the operations and quality manager told us, they would be offering them support completing the provider's quality assurance systems.

It had not been identified through the audit process that documentation was not completed in a timely way to ensure staff were aware of their care needs and any risks for that individual. Staff competencies had not been completed to evidence when new staff were competent to administer medication. The operation and compliance manager told us "I will do this for the clinical nurse lead." As the provider had recently opened the home they told us our concerns would be addressed. The day after our inspection the registered manager sent us a home improvement plan to address the shortfalls identified at the inspection.

Staff told us they felt comfortable in being able to raise any concerns they had regarding people or other staff with the management team. People and relatives we spoke with said the atmosphere within the home was good and they also felt able to approach care staff or the management team. Staff meetings were periodically held. These were an opportunity for staff to raise any concerns and for any issues they wished to raise.

The provider had not sought feedback from people so that they could evaluate the service and drive improvement. Although the registered manager told us they planned to conduct a meetings and surveys in the near future as this was a new service.

We spoke to the registered manager about their plans to develop the service over the next twelve months they told us, "I have plans to develop the roles of the care staff and develop champion specialist roles for staff and generally improve systems." They told us, they felt supported by the provider and had opportunity to regularly meet with other managers from the provider's other homes.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not ensured the safe storage, recording and administration of people's medicines.