R M D Care Services Limited

Lynmere Nursing Home

Inspection report

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Stockport
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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

Overall summary

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 was an unannounced inspection.

A registered manager was in place. 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 service met all of the regulations we inspected against at our last inspection on 17 April 2013.

Summary of findings

The home provides nursing care for up to 24 people. Accommodation is single storey and comprises of two communal lounge rooms one of which includes a dining area. The smallest lounge leads onto an enclosed rear garden. All bedrooms are single and four have en-suite facilities available. Car parking is available at the front of the building. There were 23 people living at the home at the time of our visit.

Staff working in the nursing home understood the needs of the people who lived there and we saw that care was provided with kindness and dignity. The provider had skilled staff employed at the service to make sure the care provided was in line with best practice. People using the service and their families told us they were happy with the care being provided and the staff working at the home.

Staff were appropriately trained and skilled and provided care in a safe environment. They had all received a thorough induction when they started work at the service and fully understood their roles and responsibilities, as well as the values and philosophy of the home. The staff had completed appropriate training to help make sure that the care provided to people was safe and effective to meet their needs.

Throughout our inspection we saw examples of people and their families being included and consulted in the planning of their care and were treated with dignity, privacy and respect.

The registered manager consistently assessed and monitored the quality of care using an established in house system that was being completed regularly. Workforce management was being monitored using an effective workforce intelligence system.

The provider encouraged feedback from people using the service and their families. Feedback was given in the form of complaints, comments, compliments and an annual service user satisfaction survey. People we spoke with knew how to make a complaint and felt confident to approach any member of the staff team if they required. Feedback received was used to make improvements to the service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. The provider had effective systems in place to manage risks to people's care without restricting their activities.The staff we spoke with knew how to keep people using the service safe. They could identify the signs of abuse and knew the correct procedures to follow if they thought someone was being abused.

People's medicines were managed safely by staff who encouraged them to be independent with their care when this was possible and safe to do so.

There was a system in place for assessing staffing levels against people's needs. The provider had employed staff with the right qualifications and skills to work at the home.

Is the service effective?

Good

The service was effective. We saw that people using the service and their families were involved in their care and were consulted about their preferences and choices. People received care from staff who were trained to meet their individual needs. They could also access appropriate health, social and medical support as soon as it was needed, including out of hour's services.

During the inspection staff were in the process of undertaking training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). These safeguards protect the interests of vulnerable people and help to make sure people are given the care they need in the least restrictive way. Staff had good systems in place to help them identify any changes in people's condition.

The environment had been maintained to make sure that appropriate facilities were provided to meet people's individual needs. People enjoyed the meals served at the home and could choose what they wanted to eat from a varied menu. People could choose where they ate their meals and were supported to eat and drink enough to maintain good health.

Is the service caring?

Good

The service was caring. People's care needs were recorded and staff followed the agreed plan. During our visit staff showed kindness and compassion to people using the service and their relatives.

Care being delivered was focused on meeting people's needs, making sure they were comfortable and treating them with dignity and respect at all times. People being cared for in bed were routinely checked on and spoken with by staff as part of the person's daily care monitoring.

There were areas in the home for people and their families to use if they wanted privacy away from other people. There was a choice of activities for people to be involved in if they wished.

Is the service responsive?

Good

The service was responsive. Care plans showed that written information about people's needs, preferences and risks to their care were up to date and had been reviewed regularly.

Staff communicated effectively with people to enable them to express their views about their care; future wishes were included in their care records, such as end of life care. People spoken with had consented to their care. For those who could not, the provider made sure that proper steps were taken so that decisions were made in their best interest.

Summary of findings

The service managed complaints that had been raised and people that we asked knew how to make a complaint or raise a concern. People told us they could make choices about the way they spent their time and there were enough meaningful activities for them to take part in if they wished.

Is the service well-led?

Good

The service was well led. The manager monitored incidents and risks to make sure the care provided was safe. Risk to people was minimised because the systems in place for monitoring risk were effective.

Workforce management was being monitored through the National Minimum Data Set for Social Care (NMDS-SC). The aim of the NMDS-SC is to provide workforce intelligence relied upon by government and strategic bodies to make decisions that will improve outcomes for people who use services.

Staff said they felt supported and were aware of their responsibility to share any concerns about the care provided at the home. They understood and worked within local and national best practice standards.

Lynmere Nursing 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.

This inspection took place on 17 November 2014 and was unannounced. We made an announced visit to the home on 18 and 24 November to continue the inspection and provide feedback to the registered manager.

The inspection was carried out by one inspector. Before we visited the home we checked information that we held about the service and the service provider. The provider completed a Provider Information Return (PIR) before the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information in the PIR which included incident notifications they had sent us. We contacted a social worker to obtain their views about the care provided in the home. No concerns from the local authority, Clinical Commissioning Groups (CCG) and Healthwatch had been raised since we completed our last inspection.

We spoke with thirteen people living at the home, three relatives, one visitor, one registered nurse, one cook, four health care assistants, the deputy manager and the registered manager.

During the inspection we saw how the staff interacted with people using the service. We also observed care and support in communal areas. We looked at the kitchen and all of the bedrooms. We reviewed a range of records about people's care and how the home was managed. These included the care plans for four people, the training and supervision records for 4 staff employed at the home, four people's medication records and records relating to how the home was managed.

Good

Is the service safe?

Our findings

All of the staff spoken with were able to explain how they would recognise and report abuse. Staff told us, and training records confirmed that staff received regular training to make sure they stayed up to date with the process for reporting safety concerns. We looked at records to demonstrate staff had followed the correct procedure and reported concerns to the manager who then reported these concerns to the appropriate professionals. Risks to people's safety were appropriately assessed, managed and reviewed. We looked at the care records for four people who were using the service. Each of these had an up-to-date risk assessment which reflected how their specific risks were identified and managed. Staff demonstrated their knowledge about the details in people's care plans and how to keep people safe.

During a tour of the home we looked at people's armchairs, wheelchairs, walking frames and other equipment, such as bedside protectors and pressure relieving equipment and saw that these were clean. We found communal bathrooms had been cleaned throughout the day. We noted that some carpets would need replacing in the near future however these were safe and clean. The manager had a refurbishment plan in place to address the replacement issues.

Through our observations we found there were enough staff with the right experience and training to meet people's needs. However people and relatives spoken with felt that more staff were needed at busy times particularly when they required a bed pan. For example five people said, "They [the staff] don't seem as though they are fully staffed and say you have to remember there are other people to see too", "I reckon they need an extra carer on in the daytime', "When I want a bed pan they take a long time", "I've had to wait for a bed pan up to five minutes at the longest" and "They could do with more staff night and day; they must be short staffed". A relative told us, "I press the buzzer and somebody comes eventually after two to three buzzes". Staff spoken with told us that sometimes people did have to wait a short while before their buzzers were responded to. When we asked the manager how staffing arrangements were managed at the home, they showed us a system that was being used to determine people's dependency levels. This helped to staff the home accordingly. We also looked at the staffing rota which showed there was enough staff to meet people's needs

Before our inspection, we asked a local authority social worker for their opinion of the staffing levels at the home and we were told they had no concerns about the number of staff at the home.

Most of the people living at the home spent a lot of time in their room and when asked how often staff checked on them they confirmed that staff checked on them regularly and they felt safe. One relative said, "The girls are good at keeping him happy; they say hello and there's always someone coming into his room". During our visit, we saw people were being supported to eat and drink enough to maintain good health. People spoken with and their relatives told us they were involved in the risk assessment process. Staff told us they contacted other professionals, such as GPs to share people's risks if any, when they were admitted to the home

Medicines were stored safely and records were kept for medicines received and disposed of this included controlled drugs (CD's). We looked at the medicine records for five people and found records completed were up to date. We asked thirteen people if they received the correct medication on time and all of them confirmed that they did. We observed that a person was administered medicines prescribed with specialist instructions, for example through a percutaneous endoscopic gastrostomy (PEG) feeding tube. We saw that specific pharmacist, general practitioner (GP) and dietician instructions had been followed during the administration process. PEG feeding is used where patients cannot maintain adequate nutrition by taking food orally. We saw that other special medicine instructions for people were being followed and these people had been supported to take their medicines during or after they had eaten a meal. Two relatives spoken with said, "They're on the ball with pain relief here and they review our parent's medication regularly".

The home was spacious and accommodated specialist equipment to keep people safe. Staff kept entrances and exits to the home locked to so that they could monitor who came in and left the building. This did not restrict people's movements and they could leave the home with appropriate supervision and safeguards in place if they wanted to.

Good

Is the service safe?

We saw records that showed the home held regular service user and relative meetings. At these meetings they discussed how people's diverse needs could be met to protect them from the risk of unequal treatment. We looked at records that showed the provider had effective procedures that helped to ensure any concerns about a person's safety were appropriately reported.

Good

Is the service effective?

Our findings

People's care plans included risk assessments for pressure care, falls, personal safety, mobility and nutrition. Records showed that people had regular access to healthcare professionals, such as GPs, dieticians, district nurses and opticians.

From the five care plans we looked at and discussions with people we found staff were effectively meeting people's healthcare needs. People spoken with and their relatives said, "My annual diabetic assessment is due soon but I know the manager will sort this out", "I get plenty of drinks, food's lovely and I get my medication on time; the staff are marvellous", "They treat you with respect and they see to us well", "My mother in law is always safely strapped in her wheelchair or hoist when she is being moved; she has cot sides which keep her safe when she's in bed". Care plans and risk assessments had been reviewed monthly and were up to date. Staff had made the appropriate referrals and developed individual care plans, which were being followed to support people's needs.

We saw records that confirmed nutritional risk assessments and speech and language therapy (SALT) assessments had been completed by an appropriate professional. The speech and language therapy service provides assessment and treatment for people who have swallowing or eating and/or communication difficulties.

When asked about the frequency of dental care, all of the people spoken with told us they did not have regular dental check-ups. However they confirmed they were supported by staff to maintain good dental and oral hygiene on a daily basis. People said, "Don't talk to me about dentists; I don't like them", "I would like to see a dentist; my teeth are broken". Oral health affects a person's general health, wellbeing and quality of life. The condition of a person's mouth and teeth affects his or her comfort, communication, smiling, socialising and self-confidence. If people cannot chew food adequately, they are likely to become malnourished. The nurse spoken with told us that people who used the service could access a local dentist to receive treatment whenever necessary and an appointment had already been made for the person whose teeth were broken and another person who wore dentures. For urgent dental treatment people used the local NHS out of hour's dental service.

We looked at the oral hygiene plan of two people with a PEG feeding tube and saw that records had been completed at regular intervals. This included daily brushing of the person's teeth, gums and tongue and the use of a prescribed mouthwash along with warm water swabs to prevent their lips from cracking or drying.

From our observations and the records we looked at it was apparent that people were being provided with enough fluids during the day to keep them hydrated. We saw that where people needed to have their fluid intake and output monitored, this was being recorded by staff. Where a dietician had made recommendations for staff to follow we saw records to monitor and maintain people's weight had been completed. Staff told us they knew to contact the GP and/or dietetic service if there were further issues or concerns.

With the exception of two people, all of the people spoken with were positive about the food served. One person said, "The food is very good, we always have a good choice", "The food is good and they don't give me too much". Two relatives said, "People get a decent amount of food; two choices and the cook goes round every morning, they [people] tell them what they want and they get it". Two people made negative comments about the meals served at the home. One person said, "Off the record I don't like the food, but it will do; there's always enough". Another person said, "The foods crap; not flavoured enough". However this person was made a meal of his choice consisting of roll mop herring, which the cook had provided at the person's request". He then said, "They're good that way, anything I ask for to eat they get it for me, and it's no trouble". Staff confirmed that the person preferred particular types of food and this was always catered for.

Staff had received additional mandatory and refresher training in areas to include equality and diversity, adult safeguarding, health and safety, fire safety, dementia awareness and pressure area care training. Staff spoken with told us that training was always available for staff to develop their skills and knowledge in specialist areas. However four health care assistants (HCA's) felt that medicines training would help them to support the nurses during the medication round, improve their knowledge to better recognise the side effects of medication. Following a discussion with the manager they told us they would look into providing such training for the HCAs. There was a structured supervision plan for staff and regular

Good

Is the service effective?

supervision sessions were taking place. Staff said they found these supervisions beneficial and helped with their development to fulfil their roles effectively. The registered nurse, four HCAs and one cook confirmed they had received a good induction when they started work at the home. They also told us that they had support when they needed it, and relevant refresher training was ongoing.

Towards the end of the second inspection day we noted that some staff had returned to the home to undertake Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training. DoLS are an amendment to the Mental Capacity Act 2005. They apply in England and Wales only. The Mental Capacity Act allows restraint and restrictions to be used only if they are in a person's best interests. These safeguards protect the interests of vulnerable people and help to make sure people are given the care they need in the least restrictive way. Before a person receives any type of examination, treatment or therapy they must give their permission (consent). The manager demonstrated they had a clear understanding about this legislation. At the time of our inspection nobody was subject to DoLS

Two of the care plans we looked at considered an Independent Mental Capacity Advocate (IMCA) and the criteria for the use of IMCA's in safeguarding adult cases. The purpose of the IMCA's is to help particularly vulnerable people who lack the capacity to make important decisions about serious medical treatment who have no family or friends that it would be appropriate to consult about those decisions. The role of the IMCA is to work with and support people who lack capacity, and represent their views to those who are working out their best interests.

Good

Is the service caring?

Our findings

The provider had introduced the **National Gold Standards Framework (GSF) in End of Life Care.** The National GSF is a system for staff to provide a gold standard of care for people nearing the end of life. We saw that an advance care plan (ACP) for people was recognised as a key part of good care at the home. The main goal in delivering good end of life care is to be able to clarify people's wishes, needs and preferences and deliver care to meet these needs. One person said, "They're a good lot here; oh yes I feel safe and cared for. They know what to do when I die; it's all sorted out so I'm happy".

The care plans we looked at set out people's preferences so that staff could support them to remain in the home and be comfortable at the end of their life. At the time of our inspection 22 people had an ACP and the manager discussed with us the processes and resources available to individuals who required specialist care. We saw that the families always had the opportunity to be close to their relative during this time and special arrangements would be put in place for families to stay close to their relative after they had died. There were regular assessment and reviews by nursing and medical staff to help make sure people could live and die in the place and the manner of their choosing.

People and their families spoken with told us they were happy with the care and support they received at the home. Three people spoken with made positive comments such as, "I can go to bed and get up at a time that suits me. I have my privacy and they're [staff] very caring towards me", "They're good to me and they've given me a bell to ring when I want their attention", "I get plenty to drink and enough to eat and the staff know enough about me to deliver my care well", "They're ok- they're kind". We saw staff and people who lived in the home interacting well with each other and people in their bedroom were given regular attention and support from staff. The staff promoted people's privacy and their families who had access to private spaces in the home when required. The service kept any private and confidential information relating to the care and treatment of people secure. People spoken with confirmed that staff respected their privacy and their need for time alone.

Staff had been trained in how to respect people's privacy and dignity, and understood how to put this into practice. Throughout our inspection, we saw that staff respected people's privacy and dignity when they were supporting people with their personal care. We saw staff asking people where they preferred to sit in the shared lounge and assisting them to their chosen seat. We also saw staff speaking to people in a kind, comforting and sensitive manner throughout the inspection.

The manager told us people's needs were assessed accordingly to determine appropriate advocacy representation. Advocacy services are designed to support people who are vulnerable or need help to make informed decisions and secure the rights and services to which they are entitled. The manager was in the process of discussing this service with a person to help make sure they were supported to make decisions about their health and wellbeing.

Good

Is the service responsive?

Our findings

Care plans included up to date information about what name people preferred to be known by, and we saw that staff used these names when addressing people who used the service. Information on the care plans we looked at included details about the person's health, risk assessments, personal history and personal preferences. From the four care plans we looked each plan referred to the person as an individual and planned care was person centred. The plans addressed areas such as communication, maintaining a safe environment, personal hygiene, sleep, elimination, sexuality and mobilising.

From the care files we examined we saw that people had received visits from or had visited healthcare professionals such as the GP's, chiropodists, opticians, district nurses and dentists. We saw records to show that people had attended hospital appointments and received coordinated care and support. Staff spoken with told us they thought a high standard of care was provided at the home. Daily records made by the staff caring for people were comprehensive and dated, signed and timed at various stages of the day as care had been delivered.

During the inspection we saw people who were able to move freely around the home using handrails and the aids and adaptations provided to them by specialist workers such as an occupational therapist. We saw that people who were unable to mobilise independently received care and support which was delivered discreetly and sensitively by staff. During the inspection we saw staff asking people their preferences when meals, snacks and drinks were being served throughout the day. Staff were seen checking on particular people who could not verbally communicate. In these cases other communication methods were used such as hand gestures and direct eye contact. In each situation staff were responsive to people's individual characteristics to make sure their needs would be met based on best practice and professional guidance.

We saw evidence that the provider regularly sought feedback from people and their families about the care provided. We looked at meeting notes which demonstrated that the provider was responsive to the feedback from people using the service and their families through planned resident's and relative's meetings. Feedback from the home's last satisfaction survey in February 2014 showed that on average 75 percent of respondents were satisfied with the standard of their care of the home, they [people] felt staff were approachable and they were always informed of changes to their care plan. People were also confident their complaints would be taken seriously because they were able to express their choices and felt staff took these into consideration. The remaining 25 percent were satisfied most of the time and the provider had addressed and actioned the areas where this was highlighted. Relatives also made positive comments such as; "Very satisfied with the care mum receives. The care provided is generally very good indeed", "Mum has been in three care homes prior to Lynmere and this is the only care home where we feel we have done our best for our mum", "We're very lucky to have both of our parents in this home, we are satisfied".

Staff knew how to respond to complaints and understood the complaints procedure. A relative told us that they had raised a concern and that the registered manager had addressed the issue immediately to their satisfaction. Everyone knew who to speak with if they wanted to make a complaint or had a concern and told us that they felt comfortable approaching the manager and staff about their concern. One person told us, "You can speak to the girls [staff] about anything; they know what they're doing and will keep things private". We saw information about how to complain or comment was displayed on the home notice board to guide people about they should make a complaint.

We saw that people who used the service had maintained good links with the community which helped them to engage in local community life. One person spoken with told us they were still able to attend a local club they went to before they moved into the home. Another person told us that the home had arranged for the local Vicar to visit them at regular intervals, they said, "It's very nice of them to arrange this for me as I enjoy their [vicar] visit". One relative told us they were able to visit the local pub with their husband and safeguards to protect her husband were in place.

Good

Is the service well-led?

Our findings

A registered manager was in place. 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.

All of the staff spoken with confirmed their understanding about their right to share any concerns about the care provided to people who use the service. They told us they were aware of the provider's whistleblowing policy and they would confidently use it to report any concerns about the home and if they witnessed poor practice. Staff also told us that the providers were lovely people and said, "It's a good home to work in". They told us that the manager always acted immediately on any concerns they reported. A nurse and four HCAs told us, "The manager knows her stuff".

The values and philosophy of the home were clearly explained to staff through their induction programme and training and there was a positive culture at the home where staff felt "generally happy" in their work. One relative of a person using the service said, "The girls have really helped my husband to eat and drink. He feels safe and never threatened".

The provider and manager sought feedback from the staff through staff meetings and staff handovers and used this feedback to make changes to the service. However, some of the staff spoken with felt that communication between the nurses and HCA's could be improved at staff handover times. They said, "Handovers are currently held between the nurses then the information is shared with the HCA's separately. We want to be more involved in this process to share more information and actively contribute information. This would improve communication between the manager and staff". We discussed this with the manager who explained that although the current system worked well, they would consider reviewing this to help improve outcomes for people using the service. All the staff spoken with told us they felt supported and enjoyed their work. They said, "We like working here, we're up to date with our training too." Records showed that staff received regular supervision and appraisals. There was a clear management structure at the home. A nurse and HCA staff spoken with were aware of the role of the management team. They told us that the managers were approachable and were always present in the home.

During our inspection we spoke with the registered manager and deputy manager. Both had regular contact with the people using the service, their families and appropriate professionals. This showed us they were knowledgeable about the details of the care provided to the people using the service.

The registered manager monitored the quality of the care provided by completing regular audits including medicines management, care records, admissions, and discharges and deaths. We saw that the audits had been evaluated using the Commissioning for Quality and Innovation (CQUINs) framework. The CQUIN was set up to encourage care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare. The CQUIN payment framework enables commissioners to reward excellence conditional on demonstrating improvements in quality and innovation in specified areas of care. Action plans for improvement were completed when improvements were needed.

Records showed that the manager recorded incidents that happened at the home including accidents, safeguarding incidents and incidents that prevent the service from running normally. The manager notified us of any events as required. Risk to people was minimised because the systems in place for monitoring risk were effective. Workforce management was being monitored through the National Minimum Data Set for Social Care (NMDS-SC). The manager used this information to monitor and investigate incidents and take the appropriate action to reduce the risk of them happening again. Staff were always informed about any changes that had been implemented in response to these incidents. There was an appropriate system to monitor and investigate complaints. Complaints received by the provider since our last inspection had been addressed satisfactorily by the manager.

The registered manager consistently assessed and monitored the quality of care using an established in house system that was being completed regularly. Workforce management was being monitored using an effective workforce intelligence system.