Lifeline Nursing Services Limited

St Edmunds Nursing Home

Inspection report

Worcester Road
Grantham
Lincolnshire
NG31 8SF
Tel: 01476576811

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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

Overall summary

The service provides care and support for up to 49 people. When we undertook our inspection there were 46 people living at the service.

The people who were using the services had diverse needs. Most were older people, but there were some younger adults' present. Some used wheelchairs to move about and some walked with the assistance of staff. Several people had nursing needs and were predominately nursed in bed and some had dementia and were nursed across the units, but their behaviour observed.

We inspected St Edmund's Nursing Home on 16 March 2015. This was an unannounced inspection. Our last inspection took place on 11 June 2013 during when we found the service was meeting all the standards we assessed.

There was a 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.

Summary of findings

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others. There were no people living at the home that were subject to any such restrictions. However, the recording of people's best interests was poor.

We found that people's health care needs were assessed, and care planned and delivered in a consistent way through the use of a care plan. People were involved in the planning of their care and had agreed to the care provided. The information and guidance provided to staff in the care plans was clear. Risks associated with people's care needs were assessed and plans put in place to minimise risk in order to keep people safe.

The staff on duty knew the people they were supporting and the choices they had made about their care and their lives. People were supported to maintain their independence and control over their lives. However, the deployment of staff throughout the day and the high sickness levels meant there was the potential for care and treatment to be delayed.

Medicines were kept in a safe environment. However insufficient quantities of medicines were being kept to ensure people could receive their medicines as prescribed. Staff did not always ensure the medicines were locked away.

People were treated with kindness, compassion and respect. The staff in the home took time to speak with the people they were supporting. We saw many positive interactions and people enjoyed talking to the staff in the home.

People had a choice of meals, snacks and drinks. Meals could be taken in a dining room, sitting rooms or people's own bedrooms. Staff encouraged people to eat their meals and gave assistance to those that required it. People could join in group activities, but their individual interests and hobbies were not being developed.

The provider used safe systems when new staff were recruited. All new staff completed thorough training before working in the home. The staff were aware of their responsibilities to protect people from harm or abuse. They knew the action to take if they were concerned about the welfare of an individual. There were sufficient staff to meet people's needs.

A complaints process was in place. However, this was only available in written English. No other formats were in use. This could mean that people were unaware of how to make concerns known.

People had been consulted about the development of the home. The provider had completed all the checks to ensure the quality of the service met peoples' needs. However, there had been no analysis of the audits to show whether improvements were required and lessons learnt passed on to staff. There was a plan in place to ensure the environment and equipment was updated.

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?

Requires Improvement

The service was not consistently safe.

There were insufficient staff deployed to meet people's needs.

Staff in the home knew how to recognise and report abuse.

Medicines were stored and administered safely. However, insufficient quantities of medicines were being kept and some poor practices of administering medicines were being undertaken.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff ensured people had enough to eat and drink to maintain their health and wellbeing.

Staff received suitable training and support to enable them to do their job.

Deprivation of Liberty Safeguards and the key requirements of the Mental Capacity Act 2005 were not understood by all staff.

Is the service caring?

Good

The service was caring.

People's needs and wishes were respected by staff.

Staff ensured people's dignity was maintained at all times.

Staff respected people's needs to maintain as much independence as possible.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care was planned and reviewed on a regular basis with them.

People were not supported to develop their own interests and hobbies.

People knew how to make concerns known and felt assured anything would be investigated in a confidential manner. The complaints policy was not available in different formats.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

People were relaxed in the company of staff and told us staff were approachable.

Summary of findings

Checks were made to ensure the quality of the service was being maintained, but there was no analysis of those audits to show lessons learnt or actions taken.

People's opinions were sought on the services provided and they felt those opinions were valued, as did the staff.

St Edmunds 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 16 March 2015 and was unannounced. The inspection team consisted of two inspectors, a specialist advisor and an expert by experience. An expert by experience is there to obtain the views of people who use the service, visitors and make some general observations.

Before the inspection the provider completed a Provider Information Return (PIR). 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 also spoke with the local authority and the NHS who commissioned services from the provider in order to obtain their view on the quality of care provided by the service.

During our inspection, we spoke with six people who lived at the service, seven members of the care staff, three trained nurses, four other staff members, one visiting health professional, three relatives and the manager. We also observed how care and support was provided to people.

We looked at 24 people's care plan records and other records related to the running of and the quality of the service. We found the records were kept up to date.

Requires Improvement

Is the service safe?

Our findings

People told us their needs were being met. They said there were sufficient staff on duty to ensure they could do what they liked each day. One person said, "It is a comfortable place to end my days, where I don't have to worry about anything." Another person told us, "I put up with living here", but went on to tell us how good the staff were to them and their speech and mobility had improved. They also stated their current needs were being met.

The provider employed sufficient numbers of staff to meet people's needs. However, the high levels of sickness and how staff were deployed across the home affected their ability to provide care and treatment in a timely way.

It was difficult to find staff as they were spread across the whole home, which was quite large. Two relatives told us that at weekends it was harder to find staff to talk with but had been assured by the manager the same deployment of staff happened at weekends as during the week. We heard staff calling for each other when they required assistance. One staff member said, "It's always like this." This could result in peoples' care and treatment being delayed.

The latest calculations for dependency and staffing numbers were seen. The actual hours worked by staff exceeded the required numbers of hours, according to their records. The calculations reflected other evidence we found on the day in peoples' care plans and on staff rotas. However, staff told us it wasn't so much about numbers of hours but deployment of staff and at certain times of the day it was busier than others. One staff member said, "If only we could have more staff deployed at the right times of day." Another staff member said, "It really depends if people go off sick. If the manager can't find anyone it's a struggle." Another staff member said, "We work well together as a team but sickness levels here are high. We are allowed agency staff to cover those shifts though." A visitor said, "They are rushed off their feet and need more hands." The incorrect deployment of staff and insufficient numbers of staff to cover staff absences could result in treatment and care being delayed.

We looked at the personal files of four members of staff. Safety checks had been made prior to each person commencing employment to ensure they were safe to work with people. Each file had received an audit check to ensure all the required documentation was in place. We saw additional checks had been made on each of the trained nurses to ensure they had a valid registration with the Nursing and Midwifery Council (NMC) and were considered safe to practice.

People told us they felt safe living at the home. One person said, "I feel safer here than at my family member's house." Another person told us, "I've been somewhere else which was more basic than here. So feel safer."

Staff were able to explain what constituted abuse and how to report incidents should they occur. They knew the processes which were followed by other agencies and told us they felt confident the senior staff would take the right route to safeguard people. Staff said they had received training in how to maintain the safety of people who spent time in the service. They said they felt people were safe at the home.

To ensure people's safety was maintained a number of risk assessments were completed for each person and people had been supported to take risks. For example, risk assessments were in place where someone had been at risk of falls, malnutrition, swallowing, use of bed rails and pressure ulcers. Care plans were in place and advice had been sought from specialist professionals to ensure risks were managed appropriately.

When an incident or accident happened in the home the manager quickly let the Care Quality Commission (CQC) know. They made appropriate referrals, when necessary, if they felt events needed to be escalated to the safeguarding adult's team at the local authority. This ensured people were protected against harm coming to them.

People told us they received their medicines at the same time each day. One person said, "Staff explain what they are giving me as I don't always remember." Another person told us, "Staff have managed to get some of my medicine in liquid form as I don't like swallowing tablets." We observed one person asking for some pain relief and staff promptly obtained and gave the medicine as prescribed.

Medicines were kept in a safe and clean environment. We looked at the people's medicine records and found they had been completed consistently. There was no extra information on the medicines records such as allergies or how people liked to take their medicines, which would be helpful to staff unfamiliar with the people who used the service. There were however details of how staff should check the health status of a person prior to giving some

Requires Improvement

Is the service safe?

medicines. For example before giving medicines to regulate a person's heart rate or their diabetes. Some instructions from GPs' were unclear but the staff were challenging each one as they appeared.

We found there were issues with the timely supply of medicines to the home. On the day of the inspection some prescribed medicines were not available as there had been issues with the prescription or supply. There was no opportunity for staff to check the prescription prior to it being sent to the pharmacy. The pharmacy delivery time then gave no opportunity of all medicines to be checked in by staff before a weekend. This could result in people not receiving their medicines on time and could delay treatment. The manager was trying to work with the pharmacy on those issues.

We observed medicines being administered on two occasions and noted appropriate checks were carried out and the administration records were completed. However, on one occasion the medicines trolley was left unlocked and the nurse had walked away. The trolley was not in their line of vision. This meant there was the possibility of unauthorised access to medicines.

Staff who administered medicines had received training. They told us their competence test was completed annually. We saw records of competency tests which had been undertaken within the last year. Internal medicine audits were carried out periodically by the local pharmacy. We saw the last report which rated the service as good. The medicines policy was not dated making it difficult to ascertain whether it was up to date. We looked at the recent incidents in relation to medicines administration and found action was documented to address the issues identified.

Requires Improvement

Is the service effective?

Our findings

People told us they were happy living at the home and their health care needs were looked after... They told us they liked the staff and said if they required to see a doctor or nurse staff would respond immediately. One person said, "They have gone through everything in depth with me." Relatives told us they had been informed when other health professionals needed to be called. One relative said, "They called a district nurse when [named relative] ears needed syringing."

Health and social care professionals we spoke with before and during the inspection told us they knew staff gave person centred care as they were asked for their opinions about people. One person said, "When wound care treatment needs to be revised the manager takes pressure area care very seriously and always wants to receive updates on skin care and wounds." Senior staff told us that more junior staff were good at reporting things even if they thought them minor. Staff spoke of their frustration when not able to get hold of GPs' to visit and Practice Nurses attending, who often had to make a reappointment for a GP. They felt this inconvenienced the person concerned.

We observed staff handing over between shifts. They ensured the staff coming on duty were aware of everyone's needs and what treatments were left to complete. Staff were given the opportunity to ask questions. Staff told us this was an effective method of ensuring care needs of people were passed on and tasks not forgotten. The information board in the staff area had minimal information on it but staff told us they were expected to attend the handovers before each shift to gather information. This period was also used as a learning session for staff to share their knowledge with others and to ensure staff knew other organisations to contact for advice.

The Mental Capacity Act 2005 (MCA) legislation provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make decisions themselves. Deprivation of Liberty Safeguards (DoLS) is a framework to approve the deprivation of liberty for a person when they lack the capacity to consent to treatment or care. The safeguards legislation sets out an assessment process that must be undertaken before deprivation of liberty may be authorised and detailed arrangements for renewing and challenging the authorisation of deprivation of liberty.

We observed staff asking people if they could help them with personal tasks and deliver treatment. This ensured people's rights to make choices were respected and consent was obtained prior to treatment being given.

Five staff showed that they were knowledgeable about how to ensure that the rights of people who were not able to make or to communicate their own decisions were protected. However, five staff were not aware of The Mental Capacity Act 2005 and DoLS. Only two members of staff stated said they had received training in those topics. MCA and DoLS did not appear on the training matrix we were given by the manager. Although the training audit for 2014 stated 25% of staff had completed their MCA training. There was no evidence to support these calculations. A lack of training in MCA and DoLS could mean that staff were unaware of how to protect people from harm and assess their abilities.

Staff told us that where appropriate capacity assessments had been completed with people to test whether they could make decisions for themselves. We saw these in the care plans. They showed the steps which had been taken to make sure people who knew the person and their circumstances had been consulted. However, the documentation about people's best interests was not clearly written and recorded. Therefore, we could not tell whether some information was correct.

Many of the care plans had been written over a year previously and had minimal updating since this time. However, there was a monthly review of the care plans, signed by a staff member. Plans included details about people's health care needs such as epilepsy and position changes in bed. The staff had documented when people's condition had declined. In the case of people who were receiving end of life care, staff had asked for reviews by GPs' on a regular basis so their care plans could be kept up to date. However, the form completed by staff for end of life choices was out of date and did not reflect current practice and legislation.

Staff told us that they received regular supervision sessions from the manager or their team leader. Some supervision sessions, staff told us, were as groups. They said this was when important messages needed to be passed on. We saw the supervision planner which showed senior staff were adhering to the supervision policy in place. This

Is the service effective?

monitored their performance. Staff said they were given opportunity to express their own views about their performance and this had helped staff to identify training needs and career progression.

Two staff members told us about the introductory training process they had undertaken. This included assessments to test their skills in such tasks as manual handling. They told us it had been suitable for their needs. We saw the induction records within the person's personal file. This had ensured each person was capable of completing their job role before being offered a permanent post. A staff member said, "We keep residents safe by ensuring the care staff are well trained, and we support them with any concerns they may have." Another staff member said, "New staff get good inductions." They went on to describe the introductory training process.

Staff said they had completed training in topics such as basic food hygiene, first aid and manual handling. They told us training was always on offer. The training records supported their comments. They said this helped them understand the needs of people better. The manager was aware which topics staff required to complete and we saw the training planner for 2015. However, this did not include other topics to expand staff's knowledge base and did not cover topics of illnesses which people in the home were presenting with. This could prevent staff from helping people to effectively manage their care needs.

People told us that the food was good. They had a choice of menu each day and could eat either in the dining room, sitting room or their own rooms. One person said, "The food is good enough." Another person told us if they felt hungry at night staff would find them something to eat. They said, "Weetabix in a bowl with warm milk went down well." We observed the lunchtime meal in the dining room. The room was clean and bright. We saw the meals were presented well and looked very appetising. The menu was on display. Staff told us this was the summer cycle. We observed staff offering hot and cold drinks to people throughout the day and offering the same to any visitors.

The staff we talked with knew which people were on special diets and those who needed support with eating and drinking. Staff had recorded people's dietary needs in the care plans such as a problem a person was having controlling their diabetes with their diet and when a person required a softer diet. We saw staff had asked for the assistance of the hospital dietary team in sorting out people's dietary needs. Staff told us each person's dietary needs were assessed on admission and reviewed as each person settled into the home environment. This was confirmed in the care plans. When people preferred to eat in their rooms, this had been recorded.

Good

Is the service caring?

Our findings

People told us staff were caring and kind. They told us the staff understood their needs. Every one told us they understood the staff and felt they cared for them well. One person said, “The staff are very kind.” Another person said, “I feel happy with the staff members.”

The staff were all caring and kind towards people. They were patient with people when they were attending to their needs. We observed staff ensuring people understood what care and treatment was going to be delivered before commencing a task, such as helping with a bath and choosing meals.

Staff described the actions they took to preserve people’s privacy and dignity. They said they would knock on their bedroom doors before entering. We observed staff knocking on doors before entering a room. Staff spoke quietly to people and were unhurried in their approach, always giving time for people to respond to questions and walking with them at the person’s own pace. Staff gave alternatives to people on things to do throughout the day. If people declined this was recorded in the care plans.

Call bells were sounding throughout the day but were not always answered promptly. Sometimes these went on for 5-10 minutes at a time. People told us they had used the call bell during the night and had received attention without delay. In each room we saw extendable call bell alarms so that these were easily accessible when sitting in chairs or in beds.

We observed many positive actions and saw that these supported people’s well-being. Many people appeared to enjoy a banter with staff and were laughing and joking. When anyone appeared to be withdrawn staff spoke with them quietly but respected their wishes if they did not want to join in activities.

Throughout our inspection we saw that staff in the home were able to communicate with the people who lived there. The staff assumed that people had the ability to make their own decisions about their daily lives and gave people choices in a way they understood. They also gave people the time to express their wishes and respected the decisions they made. For example, some people preferred to stay in their rooms all day but others wanted to join in every activity. Staff addressed people by their first names but also used such terms as “darling” and “sweetie”. There was no documentation in the care plans to indicate how people liked to be addressed. A staff member said, “I do ask but sweetie to be is a term of endearment.”

People had access to several sitting room areas, a dining room, quiet areas in corridors and garden areas. We observed staff asking people where they would like to be if they required assistance to move about the building. Staff ensured each person was comfortable, had a call bell to hand and had all they required for a while. Other people we observed walked or used a wheelchair to access various parts of the home and grounds. One person said, “It’s me that chooses where I sit all day. It’s usually my room.” Another person said, I like the gardens. It’s nice to see the flowers in bloom.”

Some people who could not easily express their wishes or did not have family and friends to support them to make decisions about their care were supported by staff and the local advocacy service. Advocates are people who are independent of the service and who support people to make and communicate their wishes.

Requires Improvement

Is the service responsive?

Our findings

The people we spoke with told us staff responded to their needs as quickly as they could. One person said, “Staff respond quickly when I want them.” People told us staff had talked with them about their specific needs. They told us they were aware staff kept notes about them. We saw in peoples’ care plans when such discussions had taken place and what actions, if any, needed to be taken by staff or the person using the service.

We observed staff responded quickly when people said they had physical pain or discomfort. When someone said they were in pain, staff gently asked questions and the person was given some medication. When any one used their call bell and the care required two members of staff, staff responded quickly to help each other, once the call bell had been answered.

People told us staff tried to obtain the advice of other health and social care professionals when required. In the care plans we looked at staff had recorded when they had responded to people’s needs and the response. For example, when someone who was not drinking very well. Staff undertook mouth care and ensured the person had a selection of different hot and cold drinks when required. Other appointments such as for the optician and dentist were recorded in the care plans when people had attended for routine and emergency treatment. A health professional told us they had been encouraged by staff to visit to check the skin condition of people most at risk from skin damage. Staff recorded in care plans when visits had been made by other health professionals such as community psychiatric nurses, speech and language therapists and GPs’.

We observed staff attending to the needs of people throughout the day and testing out the effectiveness of treatment. . We observed staff writing in care plans about discussions they had with other health and social care professionals and how effective treatments were. On one occasion a staff member was overheard changing a person’s hearing aid batteries, in a kindly manner.

People said there was always an opportunity to join in group events but staff would respect their wishes if they wanted to stay in their bedrooms. These included music quizzes, word games, dominoes and crafts. Some people had been encouraged to continue past interests such as cooking and gardening. One person took part in talks about gardening. The only religious service was for those of the Christian faith. Staff did not know whether people had other religious beliefs. We observed one person knitting. However one person told us they had not been able to pursue their reading hobby since their illness and had been saddened by this. They had not been offered an alternative.

There was an activities board on display. There were lots of pictures of events which had taken place inside and outside the home. These included cake making and visits out. There was very little information in the care plans about the type of interests of people. Staff were considering new ways to ensure people were not socially isolated and offered lots of alternative activities for people to join in, as a group. However, there was very little exploration of people’s individual hobbies and interests.

People told us they were happy to make a compliant if necessary and felt their views would be respected. No-one had made a formal complaint since their admission. People knew all the staff names and those of the owners and told us they felt any complaint would be thoroughly investigated and the records confirmed this. We saw the complaints procedure on display. The manager informed us they had contact with an organisation which could translate this in different languages. However, they did not have access to the information in different formats. This could mean people with a visual impairment for example may not be able to access that information. The manager told us they would rectify this. We saw the complaints log and saw that two formal complaints had been made since our last inspection. The method of investigation and outcomes had been recorded to the satisfaction of all parties.

Requires Improvement

Is the service well-led?

Our findings

People told us the home was well-led. They told us they were well looked after, could express their views to the manager and felt their opinions were valued. One person said, "Yes, I think they look after me alright." Another person said, "You know who is in charge."

There was a registered manager in place. The same manager had been in post for a number of years and was supported by a deputy manager and other staff.

Apart from yearly questionnaires for people who lived at the home and relatives, people had been encouraged to attend relatives meetings. The last meeting was in February 2015. Topics for discussion included; call bell answering and meals. People had been given the opportunity to ask questions. A relative told us, "The surveys are narrow in their answers and I've never received any feedback." A relative also said, "At meetings I do not raise my head above the parapet unless there is a real issue to discuss." We saw the satisfaction survey results for 2015. 16 had been returned out of 46. Comments included; " very happy here" and "they are very kind" and "would like weekend activities." There was no full analysis of the survey and no details of how comments had been passed on or actions required. This was the same for meetings with people who used the service and relatives.

Staff told us they worked well as a team. One staff member said, "I enjoy working here." Another said, "I like being here." They told us staff meetings were held regularly and they were encouraged to put things forward for the agenda. We saw the minutes of two meetings in January 2015. Call bells, responses from audits and documentation was discussed. Staff had been given the opportunity to voice their opinions.

Staff said the manager was available and appeared well liked. Staff told us the manager was approachable and made themselves available to them and people who used the service. They told us there was a whistleblowing policy and would feel confident to use it. They said they had confidence in the manager and deputy manager who they felt would act on any concerns. One staff member said, "The manager is brilliant and very supportive."

Plans were not in place for each person in the event of an evacuation of the building. Therefore, staff would not know how people would respond in the event of an emergency and how they should be moved. This could result in a delay in evacuating a building and put them at risk. A business continuity plan identified to staff what they should do if utilities and other equipment failed. Staff knew how to access this document in the event of an emergency.

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Requires Improvement

Is the service well-led?

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People's care records and staff personal records were stored securely which meant people could be assured that their personal information remained confidential. The manager understood their responsibilities and knew of other resources they could use for advice, such as the internet and local community agencies.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The manager of the home had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.