Abbeyfield Buckinghamshire Society Limited

The Leonard Pulham Nursing Home

Inspection report

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Ratings

Overall rating for this service	**Good**
Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Overall summary

This inspection took place on the 24 and 26 November 2014. At the last inspection on 1 July 2014 we asked the provider to take action to make improvements in how they supported staff to carry out their role and this action has been completed

At the time of this inspection the manager had been in post for nine months and was in the process of applying to the commission to become the registered manager. 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

At the last inspection in July 2014 we asked the provider to take action to make improvements in how they supported staff to carry out their roles, this action has been completed.

The home provides residential and nursing care for up to 33 older people. At the time of our inspection there were 31 people living in the home. People told us they were happy with the care provided to them, and they felt safe living in the home. Systems were in place to ensure their safety and wellbeing. For example, assessments of people's needs were completed before they moved into the home. Care planning and risk assessments took into account the persons preferences, likes and dislikes. Risks to people and staff were assessed, documented and updated.

The home was clean, tidy and well maintained. Staff were carrying out good infection control measures such as wearing gloves and aprons, however there was no infection control audit in place. This meant the provider was not able to easily identify where they could minimise the risk of infection to people. We have made a recommendation about the prevention and control of infections.

Medicines were administered safely and all records were up to date and accurate. However, we had concerns about the safety of how medicines were stored, as the medicines trolley was left open and unlocked at lunchtime when medicines were being administered.

The home had sufficient numbers of staff to support people and respond to their needs in a timely manner. People told us they had time to chat with them, and we observed lots of laughter and jokes between staff and people.

The home employed a nutritional support carer whose responsibility was to ensure the nutritional needs of individuals were met. People told us they liked the food in the home, and we saw people enjoyed their mealtime. People's health was monitored, and where their needs changed staff responded quickly and appropriately.

Staff were caring and showed respect for people. They spoke knowledgably about the people they cared for. They knew how to communicate with people and how to reassure them when they became anxious or upset.

People were cared for with dignity at the end of their life. One person told us their relative moved into the home shortly before they died. They described to us how their relative and their family were supported by compassionate and professional staff.

People told us they were encouraged to remain as independent as possible. Where potential risks were identified, these were managed in a way that respected the person's choice. Staff knew how to protect people's dignity and treated everyone as an individual. Each person could choose whether they were cared for by male or female staff.

The home provided activities to meet people's social needs. These included outings and in house activities such as sherry and piano sessions, exercises and films. Where people had difficulty in accessing the community, specially adapted taxis were hired to enable them to visit family or friends.

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?
The service was not always safe.

Whilst being administered medicines were left unattended in an unlocked medicines trolley.

Risks to people and the environment had been assessed. Staff knew how to report concerns and safeguard people.

There were sufficient numbers of skilled staff to respond to people's needs in a timely way.

Requires Improvement

Is the service effective?
The service was effective.

Staff were supported through induction, training, supervision and appraisal to carry out their role effectively.

People's human rights were protected as the provider took into consideration people's mental capacity to make decisions. Where people were not able to do this, meetings were held to ensure staff acted in the person's best interest.

People's communication needs had been identified, and staff were guided through the use of clear care plans on how to communicate effectively with people.

Good

Is the service caring?
The service was caring.

People told us they staff were caring, and compassionate. Care plans and risk assessments demonstrated people were encouraged to remain as independent as possible. People's preferences had been discussed and recorded and staff respected these.

People were cared for in a professional and caring way at the end of their life. Plans included how and where they wished to be cared for.

Good

Is the service responsive?
The service was responsive.

People's needs were assessed before they moved into the home. Care planning involved the person, so their preferences could be recorded and their rights maintained.

People's social needs were met through a range of activities and ensuring people could access their local community, family and friends.

Good

Summary of findings

The provider had systems in place to record and respond to complaints. Staff knew how to support people to make complaints. The manager made themselves available to people to discuss any concerns they had and tried to resolve these as quickly as possible.

Is the service well-led?

Good

The service was well led.

The provider did not have policies in place that were specific to the home. Some audits had not been completed, which meant the provider did not have systems in place to check the quality of some aspects of the home.

People told us the home was well managed and they spoke positively about the manager and the staff. They had opportunities to comment on how well the home was run and to give feedback on things that were important to them. The manager used this information to improve the service to people.

The Leonard Pulham 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 24 and 26 November 2014 and was unannounced.

The inspection was carried out by a lead inspector and a specialist nurse advisor. We reviewed previous inspection reports and other information we held about the home including notifications. Notifications are changes or events that occur at the service which the provider has a legal duty to inform us about. Before the inspection, we asked the provider to complete a Provider Information Return (PIR) which they did. 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 observed how care was provided to people, how they reacted and interacted with staff and their environment. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with seven people who lived in the home and two relatives. We reviewed two staff recruitment and training files. We examined five people's care files, care recording charts and records related to the medicines people received. We read a range of records about how the service was managed including policies and procedures and audits.

Before the inspection we contacted the GP and an NHS Professional for their feedback on the service. We received information from both on the quality of the service provided at the home.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living in the home. One person said "You always get help from staff when you need it." Another said they felt "absolutely safe."

Where people required medicines, trained nurses administered them. Medicine administration records were kept up to date and showed people received their medicines as prescribed by their GP. People's choices about how medicines were administered were included in the medicines file. Where specialist health professionals had given advice regarding individual's medicines these had been acted on. For example one person required their pulse to be taken prior to their medication being administered. This was to make sure it was safe for the person to have the medicines. Risk assessments related to medication were in place. The medicines trolleys and fridges were clean, locked and secured to the wall in a locked cupboard when not in use. However during lunchtime the trolley was taken to the dining room. We observed this was left open and unlocked whilst medication was being administered. This was unsafe practice as medicines were accessible to people for whom they were not prescribed. We highlighted our concerns to the staff and manager.

The home had a safeguarding adult's policy and procedure. This described the indicators of abuse and the actions staff should take if they were concerned about people's safety. Records showed all staff had received or had planned training in place in how to safeguard people from abuse. Staff knew what indicators of abuse were and how to report concerns. An independent organisation was available for staff to contact to report whistleblowing concerns, their contact details were displayed on posters throughout the home.

The home, including people's rooms and bathrooms appeared clean and tidy. Equipment used to assist people with their mobility such as hoists and wheelchairs were clean. People, who required the use of a hoist to manoeuvre, had their own hoist sling. These were cleaned regularly. To protect people and staff from the risk of infection, staff wore personal protective equipment such as gloves and aprons, and did not wear sleeves below the elbow. This meant hand washing could be carried out thoroughly and was not restricted by clothing. All staff had completed or had planned training in infection control.

Although the provider had an infection control audit tool, this had not been completed. Completing this audit would allow the provider to identify possible risks of infection and improvements that could be made to infection control practices in the home.

Risks to people's safety had been assessed. Records showed recent assessments had been completed related to the environment and included areas such as water safety, laundry safety and storage of chemicals. The equipment and premises had service contracts for emergency lighting, fire alarms and hoists maintenance to ensure they were safe to use and well maintained. Any issues found regarding the safety of the premises, systems or equipment were discussed at monthly health and safety meetings, where individual staff members were assigned responsibilities for changes or improvements.

People had the risks associated to their care assessed. Areas such as nutrition, mobility and the risk of dehydration and malnutrition were assessed, documented and monitored. Where people had the mental capacity to understand the consequences of the risks they were taking, staff supported people to maintain their independence without restricting them. For example, one person was at risks of falls, but wished to walk un supervised. This was documented in their care plan and staff were aware. Measures were in place to monitor the person's whereabouts without restricting their freedom. Each person had a personal evacuation plan detailing how they would be assisted to evacuate the premises in the event of an emergency. Plans for how the service would support people in the event of a flood or other emergency were documented.

We saw people received care and support in a timely manner. Two staff members and a person said there were enough staff to support people. One person told us they thought they could do with more staff because they had less time to chat with them when they were very busy. They described the busy times as meal times and bed times. We observed sufficient numbers of staff at lunch time and throughout the time of the inspection. Two people told us call bells were responded to quickly. Another person said that there was always 'enough qualified staff, medicines are given out correctly and there is always someone to help you, even at night'.

We were told by the manager additional staff were brought in to help support people at the end of their life. This meant

Requires Improvement

Is the service safe?

continuity of care was maintained whilst providing additional focussed care for individuals. Where staffing levels dropped due to absences, agency staff were used to fill gaps. We read in the minutes of a staff meeting how the provider reinforced the need for sufficient notice to be given by staff when they were absent from work. This allowed them to attempt to provide additional staff cover and maintain continuity of care.

The service operated safe recruitment procedures. Staff files contained Disclosure and Barring Service (DBS) checks, references including one from previous employers and application forms. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they were barred from working with adults.

We recommend the service considers the Department of Health's publication: The Code of Practice for health and adult social care on the prevention and control of infections and related guidance.

Good

Is the service effective?

Our findings

Following our inspection in July 2014, we asked the provider to make improvements to ensure staff received the support necessary to carry out their role. During this inspection we found improvements had been made. Records showed care and nursing staff received induction, training, supervision and appraisal. Where staff had not completed all the mandatory training this had been planned. Work had been undertaken to ensure records related to staff training were accurate and up to date. This meant it was easy to identify when staff needed to attend refresher training.

One staff member said "There are stacks of training opportunities… managers are very good at making training available." In their opinion and that of two other staff members the training had increased staff member's confidence and improved overall performance. For example, one staff member told us one person who lived with dementia in the home said they often felt sad. They now tried to alleviate the person's sadness by listening to them and contacting their family on the telephone.

New staff completed an induction which included mandatory training before working alone. Staff received regular supervision and appraisals. Staff said they felt supported by others in the team, one staff member told us "I do the job to the best of my ability, if not sure about something I always ask." Another said "I had an appraisal; it was helpful because I feel confident with the person supervising. I can talk to her and trust her." Staff told us they received feedback on their performance through discussions with other staff and through supervision and appraisal.

People told us they liked the food provided in the home. One person said the "food is good, and there is a wide range". The provider had employed a nutritional assistant. Their role was to identify and prioritise support to people who were at risk of poor nutrition. The nutritional support carer attended to people at lunchtime. They encouraged people's food intake by offering people food they liked .Home-made supplements were available to increase people's calorific and nutritional intake. The nutritional support carer was informed daily by the nurses of people who had lost weight and required additional support. During staff handover meetings people's nutritional needs were discussed. Records showed people's nutritional needs had been assessed and care plans reflected how people's needs were to be met. Risks associated with inadequate intake of food and drink had been completed, and where appropriate people's weight was monitored regularly. Where people required specialist advice regarding their nutrition, referrals had been made to speech and language therapists, GP's and dietitians. All staff had received or had training planned in food safety, nutrition and hydration.

The home was following the Mental Capacity Act 2005 (MCA) and making sure that the human rights of people who lacked mental capacity to make particular decisions were protected.

Training records confirmed staff had received training in the MCA and Deprivation of Liberty Safeguards (DoLS) and they showed an awareness of how it applied to their role. Nobody was being deprived of their liberty at the time of the inspection. People's mental capacity to make decisions had been assessed and documented. One person had occasional problems with a short-term memory loss; a support plan was in place to help support their memory. The care plan was personalised and included the person's wishes. It had been evaluated monthly to ensure it was kept up to date. Other people had care plans and risk assessments in place where they had made decisions about their care that could place them at risk. For one person who liked to wander, a best interest meeting had taken place. This enabled the person to agree how staff would keep them safe without restricting them. This ensured the person had the freedom to make decisions about how care was provided in a way that met their needs.

One person told us they had been impressed at how their health had been taken care of since they moved into the home. They told us staff had acted promptly and had referred them for specialist treatment when they noticed their health was deteriorating. They described how appointments had been made and they had been involved in planning the appointment and how they would be supported. People's care plans showed their health was being monitored and where necessary referrals had been made to other professionals with specialist knowledge. For example, one person's care plan recorded recommendations made from the Diabetic Specialist Nurse; we could see these had been acted upon. Feedback during staff handover included feedback from the GP's visit including actions such as a referral to a health provider. The

Good

Is the service effective?

manager told us they worked alongside other professionals to maintain people's health and wellbeing, these included the adult community health team and home oxygen nurse amongst others. A health care professional confirmed to us prior to the inspection that referrals related to people's health were made promptly, appropriately and without delay.

Good

Is the service caring?

Our findings

The staff had a caring approach to working with people. One person said "As soon as I want or need something they are there." They told us they liked the staff and the reason they gave was "Because they keep me going. I am happy to live here." Another person told us their partner moved into the home a few days before their death. They described how the staff had cared for their partner, them and their family. They described their final hours together as "beautiful". They credited this to the ability and caring nature of the staff in the home.

Staff cared for people in an attentive and positive way. They listened to what people said and responded in a way that demonstrated they understood and respected the person's wishes. For example, one person requested their meal be reduced in size at lunchtime. A staff member took the meal back to the kitchen four times before the person was satisfied. Staff had time to chat with people, we saw people engaged in jokes and laughter with staff. One person told us they thought the staff liked them, because they liked a "good chat."

Staff were able to talk knowledgeably about the people they cared for. They were aware of people's likes and dislikes and how to communicate with each person. Care plans reflected how staff should communicate with people. For example, one person's plan described how staff should consider reducing distractions and noise and only use short sentences. Another person's plan described how staff should support a person when they became anxious. The plan described how the person may be too frightened or stimulated to find touch reassuring. The care plans guided staff to be able to communicate effectively with people and to give the person the best opportunity of responding.

People were involved in the planning and carrying out of their care. Records showed people had been consulted about how they wished their care to be provided. Care plans were personalised and included people's wishes. One person had requested to see the hairdresser fortnightly and the chiropodist every six months and they did "not wish to use bedrails". Another person had requested not to have night checks included in their preferred priorities of care. Where people had a preference about being cared for by a male or a female staff member this was recorded and respected.

We attended a staff handover meeting; we heard how people's wishes were communicated to the team. One person requested to have their bedroom door kept closed. A person we visited in their room told us they were cold. The room was cold and the window was open. The radiator in their room was turned down. We spoke with the manager who changed the temperature of the radiator and fed back the person's concerns in the handover meeting. This was to ensure all staff respected the person's preference in relation to the temperature of their room.

People told us the staff treated them with respect. One person said "Staff are respectful; they ask permission before they do things". Another person told us by being given a choice of male or female carers they felt this preserved their dignity. We observed staff speaking with and about people in a respectful way. Staff knew how to protect people's privacy and dignity. One staff member said they ensured people were covered up when carrying out personal care. They also said when carrying out care for people they included them in any conversations and did not exclude them.

People told us they were supported be as independent as possible. One person told us staff encouraged them with their mobility, this ensured they maintained the level of independence they had. Another person's care plan stated the person was at risk of falls, however, the person wanted to access the community independently. Staff had encouraged the person by setting mobility goals for them to increase the distance they could walk without support. Although the person still remained at risk of falls, they understood the risk, and staff respected and supported their wish to walk into the local village independently.

Records showed people had been consulted about how they wished to be cared for at the end of their lives. Information included whether people wished to remain in the home or go into hospital. One person told us about the care they and their relative were given when their relative died in the home. They praised the staff for their compassion and professionalism. We were told by an NHS professional how the home provided good quality and safe care to people at the end of their lives. The home worked closely with the GP surgery and the palliative care team to provide appropriate care to people in the last year of their lives. Each person's had the opportunity to decide if they wished to be resuscitated, should the need arise at the end of their life. A record was kept for each person's decision.

Good

Is the service caring?

People had given written consent for staff to share the information in their end of life care plan with members of their family. These care plans were regularly reviewed. Two staff had completed the Level 3 Diploma in End of Life Care. The manager told us after the training they shared their learning with other staff. They told us in the PIR their aim is to have more staff trained in this area of care.

Good

Is the service responsive?

Our findings

People told us they were included in the planning of their care, and could make decisions and choices about how it was delivered. One person said "Generally the care is very good. The staff make me feel very special." When asked about why they were made to feel special they said because the staff always asked for their permission before carrying out their care. They said they staff took the time to discuss how they wished their care to be delivered.

Each person had received an assessment of their needs before moving into the home. This established what their needs were and how best they could be met. Risk assessments recorded the risks involved in caring for the person and how these could be reduced. Records showed people's involvement through discussions and meetings. Alongside people's physical and mental needs, care plans recorded people's likes; dislikes; interest; history and hobbies. Records were updated daily and reviewed with the person and where appropriate their family every six months or sooner if required.

Where people had specific needs due to physical or mental health concerns, specialist care was provided. Records showed people with diabetes received support from specialist diabetic nurses. Where people had mental health problems they received support and recommendations about their care from community psychiatric nurses. The care provided to people was tailored to each individual person's needs.

People's social needs were also considered as part of the care provided at the home. One person told us about how important it was to them to get out into the community. They said "We do some nice things together. We have outings and we go to places to buy things. I am in this wretched thing (wheelchair). They hire a van so I can put this in. For Christmas I am going to my daughters, they have arranged a taxi for me." Another person told us "There are lots of activities going on, something every day. The staff encourage me to join in; otherwise I would just be lazy."

Some of the activities provided included a knitting club, art club, sherry and piano sessions, exercises, bingo, quizzes and black and white films group. Outings were available to people to places of interest. Religious services were attended in the community and in the home to meet people's religious needs.

The provider had a complaints policy. Most people told us they knew how to raise a complaint or concern. One person told us they did not. Two relatives stated 'Staff are very keen for concerns to be raised.' Staff knew how to support people to make a complaint or raise a concern. They told us all concerns were dealt with quickly by the manager. We observed how concerns were dealt with by the manager when people raised them. Immediate action was taken to resolve any issues people had. Information about people's concerns were recorded and handed over to staff in meetings and handover. The manager told us they did not have a complaints log, and they would introduce one. No formal complaints had been made since our last inspection. The manager told us how relatives had raised concerns about the laundry and the food being provided to people. Records showed how action had been taken to resolve the issues.

The manager told us they made themselves available to people and relatives so that concerns could be dealt with quickly. People could contact the manager in person, by email or by telephone. At the time of our inspection the manager told us they were looking to redesign the complaints leaflet to make it easier for people to understand. The complaints leaflet was included in each person's "Residents pack". This included relevant information for each person living in the home about how the home was run.

Good

Is the service well-led?

Our findings

At the time of the inspection the manager had been in place for nine months. We read policies for areas such as infection control and medication errors. However these were general policies and had not been tailored to the specific needs of the home. An audit tool was in place but had not been used to review the effectiveness of the clinical policies and the practice of staff. Without the use of a clinical audit the provider was unable to assess how their practice compared to recommended good practice.

Other audits had been completed and action plans were in place to improve the safety and quality of service to people. For example, health and safety audits.

People told us the home was well managed and they spoke positively about the manager and staff. One person said "Everything seems to run smoothly, everyone seems to know what their job is. They all know what they are doing."

Staff spoke positively about the manager's skills and knowledge. One staff member said "Since she has taken over she has done a really good job of improving things." Another staff member said "If I am unsure about an issue or problem I can talk to the senior staff. It's not about us it's about the residents".

The home had a reward system where every three months people who lived in the home, families and staff had the opportunity to nominate a staff member who they believed had worked hard and 'gone the extra mile'. From the nominations one person was designated 'employee of the month'. In acknowledgement of their work they were awarded a certificate and voucher.

Good practice was also acknowledged through the use of the "Wellbeing Tree". People and staff had the opportunity to record good practice by writing it down on a leaf and placing it on the tree.

Support also came from the board of trustees, who met regularly with the manager to discuss how the home was running.

People and families also had the opportunity to feedback their experiences and opinions on the running of the home by completing a questionnaire. As a result some changes had been made to the way care was provided. For example, notice boards had been placed in people's rooms to aid communication between staff and family members and people. People had requested access to a minibus to get out and about more, the manager was investigating this possibility.

There was a system to report and learn from incidents and accidents. These were reviewed regularly and action plans were in place to prevent reoccurrence.

The values of the service were caring, honesty, openness and respect. We saw how these were implemented in the home during the inspection. Staff told us they felt they worked as a team and all helped each other. They said the manager was approachable and listened to their concerns and ideas for improvement. They could raise issues in team meetings and individually with the manager. They knew how to respect the people they cared for and each other. Staff meeting minutes demonstrated how the manager monitored the culture within the home, addressing problems which may impact on the care delivered.

The home is managed by a board of trustees. The executive committee and the house management committee met with the registered manager every three months. This was to ensure all parties were kept up to date with the management of the home. This gave them the opportunity to discuss issues, ideas and planning for the future. The manager was supported in their role by the members of the board. Recent structural changes to the management of the home ensured there were clear lines of accountability and responsibility between the managers in the home and the board of trustees.