Alliance Care (Dales Homes) Limited

Lawn Park Care Home

Inspection report

Lucknow Drive
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Nottinghamshire
NG17 4LS

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Date of inspection visit:
19 July 2016
20 July 2016

Date of publication:
16 August 2016

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

Summary of findings

Overall summary

This inspection took place on 19 and 20 July 2016 and was unannounced.

Accommodation for up to 49 people is provided in the service over two floors. The service is designed to meet the needs of older people. There were 38 people using the service at the time of our inspection.

A registered manager was in post but she was not available during the inspection. 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.

Systems were in place for staff to identify and manage risks and respond to accidents and incidents. However, risks to people were not always safely managed.

Sufficient staff were on duty to meet people's needs during our inspection but identified staffing levels had not been met a number of times in the previous month.

People felt safe in the home and staff knew how to identify and respond to potential signs of abuse. Staff were recruited through safe recruitment practices. Medicines were safely managed.

Staff received appropriate induction, training, supervision and appraisal. People's rights were protected under the Mental Capacity Act 2005. People received sufficient to eat and drink. External professionals were involved in people's care as appropriate. However, the adaptation, design and decoration of the service could be improved to support people living with dementia.

Staff were kind and knew people well. People and their relatives were involved in decisions about their care. Advocacy information was made available to people.

People generally received care that respected their privacy and dignity and promoted their independence.

People received personalised care that was responsive to their needs. Care records contained information to support staff to meet people's individual needs.

A complaints process was in place and staff knew how to respond to complaints.

People and their relatives were involved or had opportunities to be involved in the development of the service. Staff told us they would be confident in raising any concerns with the registered manager and that appropriate action would be taken.

The provider and registered manager were meeting their regulatory responsibilities. There were effective systems in place to monitor and improve the quality of the service provided.

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.

Systems were in place for staff to identify and manage risks and respond to accidents and incidents. However, risks to people were not always safely managed.

Sufficient staff were on duty to meet people's needs during our inspection but identified staffing levels had not been met a number of times in the previous month.

People felt safe in the home and staff knew how to identify and respond to potential signs of abuse. Staff were recruited through safe recruitment practices. Medicines were safely managed.

Is the service effective?

Good

The service was effective.

Staff received appropriate induction, training, supervision and appraisal. People's rights were protected under the Mental Capacity Act 2005.

People received sufficient to eat and drink. External professionals were involved in people's care as appropriate. The adaptation, design and decoration of the service could be improved to support people living with dementia.

Is the service caring?

Good

The service was caring.

Staff were kind and knew people well. People and their relatives were involved in decisions about their care. Advocacy information was made available to people.

People generally received care that respected their privacy and dignity and promoted their independence.

Is the service responsive?

Good

The service was responsive.

People received personalised care that was responsive to their needs. Care records contained information to support staff to meet people's individual needs.

A complaints process was in place and staff knew how to respond to complaints.

Is the service well-led?

Good

The service was well-led.

People and their relatives were involved or had opportunities to be involved in the development of the service. Staff told us they would be confident in raising any concerns with the registered manager and that appropriate action would be taken.

The provider and registered manager were meeting their regulatory responsibilities. There were effective systems in place to monitor and improve the quality of the service provided.

Lawn Park Care Home

Detailed findings

Background to this inspection

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

The inspection team consisted of an inspector, an Expert by Experience and a specialist nursing advisor with experience of dementia care. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before our inspection, we reviewed the information we held about the home, which included notifications they had sent us. A notification is information about important events which the provider is required to send us by law.

We also contacted visiting health and social care professionals, the commissioners of the service and Healthwatch Nottinghamshire to obtain their views about the care provided in the home.

During the inspection we observed care and spoke with four people who used the service, five visitors, a visiting healthcare professional, the cook, a catering assistant, the housekeeper, a domestic staff member, a laundry staff member, four care staff, a nurse and two representatives of the provider. We looked at the relevant parts of the care records of six people, three staff files and other records relating to the management of the home.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe. A person said, "My health's improved massively, I feel safe."

Staff were aware of the signs and symptoms of abuse and told us they would report any concerns to the registered manager. Staff were also aware of the procedure for reporting to the local authority safeguarding team. A safeguarding policy was in place and staff had attended safeguarding adults training. Information on safeguarding was available to give guidance to people and their relatives if they had concerns about their safety. Appropriate safeguarding records were kept.

Risks were not always managed so that people were protected from avoidable harm.

We observed people being assisted to stand and mobilise and being moved using a hoist. Hoists and turning aids were used safely and people were reassured by staff during the process. People were mostly assisted to stand using safe techniques including handling belts. However, we observed two staff assisted a person using an unsafe procedure which put the person at risk of harm. We raised the issue with management who agreed to take action.

There were pressure relieving mattresses and cushions in place for people at high risk of developing pressure ulcers, they were functioning correctly and set appropriately for the people using them. Records were kept of hourly or two hourly checks of people who remained in bed or required assistance with re-positioning. However, we saw that although people were checked regularly it was not always recorded that they had been repositioned in accordance with the instructions in their care plan or at the top of the repositioning charts. This meant that there was a greater risk of people suffering skin damage.

We saw that the premises were well maintained and checks of the equipment and premises were generally taking place, although water temperatures for bathroom and toilet sinks were not being recorded and we found two sinks where water was of a high temperature. We saw that action was taken promptly when issues were identified from premises and equipment checks.

Staff did not always carry out their work so that risks to people were minimised. We observed that cleaning trolleys were left unattended in corridors on a number of occasions. Potentially harmful liquids were stored on the trolleys. We saw that sluice rooms were also left open on a number of occasions. Harmful liquids were stored in one of the sluice rooms. This meant that people who used the service were put a greater risk of avoidable harm.

There were plans in place for emergency situations such as an outbreak of fire. However, personal emergency evacuation plans (PEEP) were not in place for all people using the service. This meant that there was a greater risk that staff would not have sufficient guidance on how to support people to evacuate the premises in the event of an emergency. A business continuity plan was in place to ensure that people would continue to receive care in the event of incidents that could affect the running of the service.

Risk assessment tools were used to assess people's risk of falls, developing pressure ulcers and nutritional risk. When bed rails were in use to prevent people falling out of bed, a risk assessment had been completed to ensure they could be used safely. Risk assessments identified actions put into place to reduce the risks to the person and were reviewed regularly.

We saw documentation relating to accidents and incidents and the action taken as a result, including the review of risk assessments and care plans and the involvement of external professionals in order to minimise the risk of re-occurrence. Falls were analysed to identify patterns and any actions that could be taken to prevent them happening.

People told us their belongings were safe. A person said, "Yes, my possession are safe. I can leave [my bedroom] door open."

People told us there were generally enough staff to meet their needs. A person said, "They seem to always have enough staff. I collapsed, staff were there in seconds." Another person said, "There's a quick response to the bell." A third person said, "The staff can be a bit slow sometimes but it's okay."

Staff views were mixed on whether they thought they had enough staff. Care staff generally felt that staffing levels were fine when they were fully staffed; however, they told us that there had been a number of days where they had not been fully staffed due to staff absence. Domestic and laundry staff did not always feel that they had sufficient time to complete their work effectively; however, we saw that the premises and laundry were clean.

During the inspection we observed staff attending to people's needs. We saw staff were very busy but worked collaboratively to ensure people's needs were met as quickly as possible. However, we noted there were a large number of people who required the assistance of two staff and felt the staffing levels influenced the approach to care which was at times task orientated. Staff told us they felt staff worked together well and provided help and assistance to each other, but sometimes people had to wait due to staff availability.

Systems were in place to identify the levels of staff required to meet people's needs safely. A staffing tool was used to calculate staffing levels. However, we saw that the identified staffing levels had not been met on a number of days in the last month due to staff absence. Staffing levels had been met during the week of our inspection.

Safe recruitment and selection processes were followed. We looked at recruitment files for staff employed by the service. The files contained all relevant information and appropriate checks had been carried out before staff members started work.

People had no concerns with how their medicines were managed. We observed the administration of medicine; staff checked against the medicines administration record (MAR) for each person and stayed with the person until they had taken their medicines. MARs contained a photograph of the person to aid identification, a record of any allergies and their preferences for taking their medicines. MARs confirmed people received their medicines as prescribed.

Processes were in place for the ordering and supply of medicines. Staff told us they obtained people's medicines in a timely manner and we did not find any evidence of gaps in administration of medicines due to a lack of availability.

We saw there was a record of the use of medicines which had been prescribed to be given only as required

but no protocols to provide staff with additional information on when to give this medicines and how to use them safely. We discussed this with management and they supplied staff with documentation for this during our visit and staff said they would put this into place immediately.

Medicines were stored securely in locked trolleys, cupboards and a refrigerator within a locked room. Temperature checks were recorded daily of the room and the refrigerator used to store medicines. On the first day of the inspection the room and fridge temperatures were above the recommended levels to ensure that medicines are not exposed to temperatures that could affect their effectiveness. The temperatures for previous days were fine and staff told us that an air conditioning unit was planned to be fitted to ensure that the room did not get too hot in the future.

Staff administering medicines told us and we saw documentation indicating they had received competency checks for medicines administration. They told us they had completed training in medicines administration and records confirmed this.

Good

Is the service effective?

Our findings

People told us that staff were sufficiently skilled and experienced to effectively support them. A person said, "Care is very adequate, very good, I'm well looked after." A visiting professional told us that staff confidence had recently increased and the home had improved as a result. We observed that staff generally competently supported people.

Staff felt supported by management. They told us they had received an induction which prepared them for their role. Staff also told us they had access to training to enable them to keep themselves up to date and they felt they had the knowledge and skills required for their role.

Staff told us they had regular supervision. We saw some completed supervision documentation which showed that staff had opportunity to discuss their role. Supervision sessions were also used to check that staff had understood and applied training that they had received. Training records showed that staff attended a wide range of training which included equality and diversity training. Systems were in place to ensure that staff remained up to date with their training.

We saw staff asked permission before assisting people and giving them choices. Where people expressed a preference staff respected them.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the DoLS. We checked whether the service was working within the principles of the MCA.

The requirements of the MCA were being followed. When a person lacked the capacity to make some decisions for themselves, a mental capacity assessment and best interests documentation had generally been completed. One person did not have assessment and best interests documentation in place for the use of equipment to monitor when they were getting out of bed. Staff agreed to put this in place.

Each person's care record contained a care plan entitled "Rights, consent, and capacity" which indicated whether the person was able to consent to decisions about their care and how staff could maximise their participation in decisions.

When bed rails were used consent for their use had been obtained from the person themselves or there was documentation to indicate the person's relative had been consulted about the person's wishes. When people were being restricted, DoLS applications had been made.

Staff were able to explain how they supported people with behaviours that may challenge others and care records contained guidance for staff in this area.

We saw the care records for people who had a decision not to attempt resuscitation order (DNACPR) in place. There were DNACPR forms in place and they had mostly been fully completed, however, staff agreed to contact the GP to review one DNACPR that was not fully completed.

People spoke positively about the food choices available and told us that they received meals that met their needs. One person said, "The food is very good." Another person said, "Food, I've no complaints. I could get anything I wanted." People told us that they had sufficient to eat and drink. We saw that people were offered drinks throughout the inspection.

We observed the lunchtime meal. People generally received their meals promptly; however, we observed that two people waited 30 minutes to receive their meal in the dining room. When people's meals were brought to them, staff explained what the meal was and checked with them if they needed the food cutting up or whether they needed assistance. Staff were attentive to people's needs and offered them encouragement when they needed prompting. When a person needed full assistance with their meal, staff explained what was on the plate and talked with the person as they assisted them.

People's care records contained care plans for eating and drinking and there were records of their preferences and the support they required. Nutritional risk assessments had been completed and care plans were in place with actions to reduce the risks to people for example, choking. The food and fluid charts we examined indicated people were supported to have a satisfactory food and fluid intake. People were weighed monthly as required and appropriate action was taken if people lost weight.

People told us they were supported with their health care needs. A person said, "I've been out to the dentist. A [staff member] took me by wheelchair in a taxi." Another person said, "If I've had to go out to hospital someone from here came with me. I hate hospitals but had to go for a chest scan, one of the [staff] went with me and waited and they changed shift at the hospital." A visitor said, "[My family member] has had some skin infections and water infections but [staff] picked up on it straight away."

Care records contained records of the involvement of other professionals in the person's care, including the GP, specialist nurses, SALT, dietician, optician and chiropodist. Staff told us they were able to contact the GP when necessary and they were able to obtain a visit.

When people had a pressure ulcer or a wound, an initial assessment had been completed and detailed information was available about the dressings and wound management products required and the frequency of dressing changes. However, wound re-assessments to monitor progress had not been completed as frequently as we would have expected. For example a person had been admitted with a grade 4 pressure ulcer 11 days prior to the inspection. An initial assessment had been completed but there was no other record of assessments following this. We were told the tissue viability nurse was due to visit to assess the wound, the day after the inspection. We reviewed the records of another person who had had previous pressure ulcers and saw wound assessments had mostly been completed on a monthly basis. This was less frequent than would be expected and meant that there was a greater risk that the progress of wound healing would not be closely monitored.

Limited adaptations had been made to the design of the home to support people living with dementia. We found people's bedrooms were not clearly identified. Handrails were the same colour as the surrounding walls and would be difficult for people with visual difficulties to distinguish on two of the floors. Bathrooms

and toilets were not clearly identified and there was no directional signage to support people to move independently around the home.

Good

Is the service caring?

Our findings

People told us that staff were kind, caring and considerate. A person said, "I don't like the hoist, don't like the swinging. But [staff] are reassuring." A visitor said, "[Staff] are very attentive. They've been in three times in the last hour even though I'm here. I see them going to other people without relatives, so I know it's not for my benefit."

Staff impressed us with their knowledge of the people they cared for and their individual preferences. They talked with them about things which were important to them and reminded them when they were expecting family visitors.

We saw very good interactions between staff and the people they cared for. These interactions indicated empathy for people and a caring approach by staff. Staff greeted people and visitors warmly and chatted with them in a relaxed manner.

People told us they were unaware of the contents of their care plans. However, we saw that care records contained information which showed that people and their relatives had been involved in their care planning. Care plans were person-centred and contained information regarding people's life history and their preferences.

A visitor said, "[My family member]'s a very regimented person, worries about things being just so and timing, If his medication came 10 minutes late he'd be unhappy. So they discussed it with him and agreed fixed times [for his medication]." Another visitor said, "I've been involved in a care plan when [my family member] came in. We've visited it again and the end of life plan."

Advocacy information was available for people if they required support or advice from an independent person. Where people could not communicate their views verbally their care plan identified how staff should identify their preferences and staff were able to explain this to us.

We observed that people were generally treated with dignity, however, on two occasions people's dignity was not fully respected. We observed three people sitting in the lounge in wheelchairs close to the lounge chairs. Staff had placed the people's wheelchairs in a line and as a result people were unable to interact or engage with other people. After approximately 15 minutes staff came into the lounge with a hoist and moved people to lounge chairs one at a time. We also saw a staff member remain standing when assisting a person, who was sitting, to eat and drink.

People felt that their privacy and dignity were respected. A person said, "Yes, staff knock on the door every time." We saw staff took people to private areas to support them with their personal care and saw staff knocked on people's doors before entering. The home had a number of areas where people could have privacy if they wanted it.

Staff were able to describe the actions they took when providing care to protect people's privacy and

dignity. We saw that staff treated information confidentially and care records were stored securely. The language and descriptions used in care plans showed people and their needs were referred to in a dignified and respectful manner.

We observed that people were supported to eat their meals independently where appropriate. Staff told us they encouraged people to do as much as possible for themselves to maintain their independence.

Staff told us people's relatives and friends were able to visit them without any unnecessary restriction. Information on visiting was displayed in the home and in the guide for people who used the service. A visitor said, "I come five times a week, any time." Another visitor said, "I'm welcomed as a visitor, get a cup of tea."

Good

Is the service responsive?

Our findings

People we talked with mostly told us they were able to get up when they wished, however, one person said staff worked along the corridor and they had to wait until staff were able to assist them. We overheard staff communicating with each other about which people were ready to get up and those who wished to remain in bed for longer, suggesting people were given choice and their preferences were considered. We saw that call bells were responded to promptly.

People's views were generally positive about the activities that were provided. A person said, "[Staff] take me out sometimes by wheelchair, a walk around the lake or have lunches out." A visitor said, "They have a singer on. [My family member] likes to go to that every six weeks."

The dates of activities and events were displayed in the main reception of the home and also included in the regular newsletter sent to people and their relatives. External entertainers visited the home and during our inspection we saw that a dog had been brought into the home to interact with people who used the service. We also saw people playing dominoes.

A pre-admission and admission assessment had been completed to provide information about people's care and support needed when they first came to the home. Care plans were in place and had been reviewed monthly and updated as necessary to provide information about people's care and their preferences in regard to their care.

Where people had ongoing health needs their care plans contained detailed information about the care they required and signs staff should look for which would indicate a deterioration in their health.

Care records contained information regarding people's diverse needs and provided support for how staff could meet those needs. We saw that people were supported to attend religious activities in line with their preferences.

People were unaware of a formal complaints process but told us that they would be comfortable raising any concerns with management. A person said, "Little niggles get sorted, I've had no need to complain about anything big." A visitor said, "I did go higher for one thing, the [registered] manager said she'd fix it and she did." Another visitor said, "We've had no issues, but I would go to the office."

Complaints had been handled appropriately. Guidance on how to make a complaint was in the guide for people who used the service and displayed throughout the home. There was a clear procedure for staff to follow should a concern be raised.

Staff were aware of the complaints process and the action they should take if a person raised a concern or a complaint. They said they received feedback about complaints either individually or as a group at handover.

Good

Is the service well-led?

Our findings

Most people were unaware of meetings for people who used the service and their visitors or surveys taking place. However one person said, "There was a survey recently by a [staff member] similar to what you're doing." Another person said, "We are asked a lot of the "Do they treat you right?" sort of questions." We saw that meetings for people who use services and visitors took place where comments and suggestions on the running of the service were made.

Feedback was provided to the home electronically using an electronic tablet on a stand in reception or using another tablet which could be taken directly to people who used the service and their relatives. Feedback was also received from staff and visiting professionals. Feedback received via this system was sent immediately to the registered manager and the regional manager who could then ensure that actions were taken in response to the feedback if required.

We saw feedback had been provided by people who used the service, relatives, visiting professionals and staff. Actions had been taken where appropriate. The main reception also contained a notice stating that the registered manager had an "open door policy" and that people could speak with her at any time if they wanted to provide feedback.

A whistleblowing policy was in place and contained appropriate details. Staff told us they would be comfortable raising issues using the processes set out in this policy. The provider's values and philosophy of care were in the guide provided for people who used the service. Staff were aware of those values and were observed to act in line with them during our inspection. A staff member said, "We are expected to be caring and compassionate."

People felt that the home had a good atmosphere. A person said, "I was previously in a care home for two weeks but couldn't wait to get out. I came here and it was like a breath of fresh air. They made me comfortable, the room is as I want it with things from home." Another person said, "It's just like having your own family looking after you. I wouldn't change a thing." A visitor said, "You couldn't find a better home. This is a real home, you can feel it." Staff were positive about their work and told us they worked well as a team. A staff member said, "I love the home. It's really nice working here." Another staff member said, "It's an amazing atmosphere. You can't beat coming in on a morning with everyone smiling at you."

People and visitors were positive about the registered manager. A person said, "The [registered] manager, she's okay, if I needed her she'd be here." A visitor said, "The [registered] manager knows me, she's very nice, especially likes [my family member], they get on."

Staff told us they felt the leadership of the home was good. Staff were positive about the registered manager. A staff member said, "The [registered] manager is lovely and approachable." Staff told us they had a good relationship with the registered manager and they felt well supported.

Staff said there were no overall staff meetings but the manager would get a group of staff together on a shift

and meet with them group by group. We saw that staff meetings took place and the registered manager had clearly set out her expectations of staff.

Staff told us that they received feedback in a constructive way. They also spoke positively of the support they had received following a serious incident at the home and the positive feedback they had received from the provider.

A registered manager was in post but she was not available during the inspection. We saw that all conditions of registration with the CQC were being met and statutory notifications had been sent to the CQC when required.

The provider had a system to regularly assess and monitor the quality of service that people received. We saw that regular audits had been completed by the registered manager and also by representatives of the provider.

Comprehensive audits were carried out in a range of areas including infection control, medicines, food safety, health and safety and care records. A daily walkaround of the home was completed which checked the cleanliness of the home, observed staff practice and ensured that recording charts (food, fluid and positional) were being accurately completed.