Renaissance Care Homes Limited

Mendip Lodge

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

Summary of findings

Overall summary

This was an unannounced inspection carried out on the 29 and 30 January 2018. At out last inspection 15 November 2015 the service was rated good. At this inspection the service remained Good overall but some improvements were needed with the management of medicines.

Mendip Lodge as a care home provides accommodation and personal care to people as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home can accommodate 16 older people, some of whom are living with dementia. On the days of our inspection there were 14 people and a new admission into the home on our second day making it 15. The home is a detached property set out over two floors and is situated in a residential area of the village of Claverham.

The service has a registered manager. This is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

All the people we spoke with said they felt safe at Mendip Lodge. Staff supported people to be as independent as they wanted to be and protected them from risks to their safety. Staff were trained in protecting people from abuse and understood their responsibilities to keep people safe.

There were enough staff to keep people safe and to support them with activities. The provider's recruitment procedures ensured as far as possible that only staff suited to work at the service were employed.

People received their medicines at the right times but the arrangements for the management of medicines were not always safe. Medicine records were not accurate and some medicines had gone missing.

The premises were clean and hygienic. Staff practised effective infection control.

People's choices were respected and they were not restricted in any way. People spent their time the way they wanted. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and systems in the service supported this practice. The service ensured peoples human rights were protected and their cultural needs promoted.

Staff completed a range of training to help ensure they had the skills and knowledge they needed to provide effective care. The registered manager and staff had a working knowledge of the Mental Capacity Act 2005 and understood the importance of people consenting to their care.

People had a choice of meals which they said they enjoyed. Mendip Lodge was decorated to people's taste and their personal accommodation was personalised.

People told us the staff were caring and kind. Staff communicated with people in a positive and compassionate manner and in ways that met people's communication needs.

People and their relative's views were sought and acted upon. People were treated with dignity and their privacy was respected. People consistently experienced care and support that was planned to meet their present and future needs.

People experienced positive outcomes as a result of the support they received. The registered manager and staff shared the same vision which placed people using the service at the centre of decision making.

The service worked closely in partnership with other services to support people to achieve their aspirations. The registered manager worked on making people feel the service was their home.

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 always safe.

People were protected from the risk of abuse.

We found some concerns regarding the management of medicines. Some medicines had been recorded incorrectly.

There were enough staff to meet people's needs.

Risks associated with people's care had been identified and plans were in place to help minimise the risk occurring.

Is the service effective?

Good

The service was effective

Staff were knowledgeable and had the skills and support to carry out their roles and responsibilities.

The registered provider was meeting the requirements of the Mental Capacity Act 2005.

People received a well-balanced diet which met their needs and their preferences.

People had access to healthcare professionals when required.

Is the service caring?

Good

The service was caring.

People who used the service and the staff had a good relationship with each other.

Staff were respectful and supported people to maintain their independence.

Staff respected people's privacy and dignity and ensured their choices were respected.

Is the service responsive?

Good

The service was responsive.

People received care and support that was centred on their personal individual needs.

People were supported to follow their interests and take part in social activities.

The provider had a complaints procedure and people were encouraged to talk with the registered manager and staff about any concerns.

Is the service well-led?

Good

The service was well led

People who used the service, their relatives and staff felt supported by the registered manager.

The registered provider had systems in place to monitor the service and to ensure a good standard was maintained.

People were involved in the service and their views were sought. People, relatives and visiting health professionals completed questionnaires to give their views about the service.

Mendip Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. This was a comprehensive inspection that took place unannounced on the 29 and 30 January 2018.

The inspection team consisted of an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert by experience had experience of older people with dementia. Before our inspection visit we reviewed the 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 looked at information received from local authority commissioners. Commissioners are responsible for finding appropriate care and support services for people. We reviewed the provider's statement of purpose; this is a document which includes a standard required set of information about a service. We also reviewed the notifications submitted to us; these are changes, events or incidents that providers must tell us about.

We spoke with nine people who were using the service, two relatives and two visitors. We looked at the care records of four people. We also spoke with the registered manager and four care workers. We looked at a staff recruitment files; at records relating to care, staffing, medicine, health and safety and quality assurance.

Requires Improvement

Is the service safe?

Our findings

People continued to feel safe with the support they were receiving. We asked people if they felt safe and they said they did. One person told us, "Yes, I do feel safe. I have lived here quite a long time. It is everything, (that makes me feel safe) I know them all." Another person said "Safe, oh yes I feel very safe, they are very good here. There's people all round you. I talk to everyone."

Staff knew how to identify and raise any concerns about peoples' safety. Staff had received safeguarding training and demonstrated an understanding of how to identify potential concerns and what to do. Staff were able to tell us who they would go to with concerns. One staff member told us, "If anyone was in potential danger I would contact the manager." One person said "I'm not worried about any member of staff, no" and another said "No; not worried about any staff, they're all good."

Staff were aware that the service had a safeguarding and a 'whistle-blowing' policy. When concerns were raised the registered manager notified the local safeguarding authority and CQC in line with their policies and procedures and matters were fully investigated. There were notices up around the home reminding everyone that the home had 'zero tolerance' towards any abuse. One staff told us, "If I was concerned and nothing was done, I would raise it again and if nothing happened I would put in a formal complaint by informing CQC."

The identification of risks to the service and individuals were well managed. People had risk assessments in place to guide staff in providing safe care and support. This included nationally recognised tools for assessing any nutritional risks or risks associated with pressure damage to the skin. Records had comprehensive risk assessments in place for people. These set out what staff had to do to reduce the risk. Where appropriate, people had falls risk assessments, risk assessments to prevent choking, and moving and handling. Staff were aware of these plans and we observed staff practice matched the plan in place. These were regularly reviewed and monitored. The service kept the control measures to a minimum so that people could keep their independence. For example there was a pressure alarm mat in one person's bedroom so he was not restricted from getting out of bed but staff knew they would need to go and check that the person was moving safely. This meant that people could continue to make decisions and choices for themselves.

Staff continued to be recruited safely through the service's recruitment processes. The recruitment procedure included processing applications, conducting interviews and seeking references. We saw checks were made before staff began work, including a Disclosure and Barring Service (DBS) check. The DBS checks assist employers in making safer recruitment decisions by checking prospective staff members are not barred from working with people.

There were enough staff to support people safely. Staff said they felt there were sufficient staff to meet people's needs and their comments included "Yes, there is enough staff. Staffing levels are frequently reviewed according to the needs of the resident. We adapt to the needs of the resident, we never use any agency staff." One person told us "I would have thought there was enough staff. I haven't actually asked for help, I pretty much look after myself, I don't know if there is a call bell" and another said "Enough staff?

Ample, we all get on together."

During the inspection, we saw that there were sufficient numbers of staff on shift to support people and rotas showed that staffing levels were consistent. Staff had time to support people in the way they preferred. People were not rushed. For example, at lunch time one person needed support with his meal, he was supported by a staff member at a pace that was suitable for him. Staff interacted positively and encouraged the person throughout the meal.

Medicines were not always managed safely. The home used an electronic system for giving out medicines. Staff used an electronic, handheld device which told them when to give the medicine, informed them if a medication had been missed, kept a balance check and a photograph of the person who the medicines belonged too. Having photographs helped staff that may not be familiar with people to identify them.

Some people had been prescribed PRN (as required) medicines. However there were no written protocols in place which ensured people who were unable to ask for their medicines got them consistently from staff. There was not enough information provided for staff administering the medication on the signs and symptoms they should look for before deciding to give PRN medicine.

Medicines were generally stored safely, including controlled medicines. However, oral medicine bottles had not always been dated when opened. This meant there was a risk that staff would not know when medicines had expired. Creams and lotions had also not been dated when opened which meant that staff would not know when they were no longer safe to use. For example, a tub of cream for one person we looked at had been opened but not dated. The dispensing label was dated 2014, but because staff had not labelled the tub when they opened it there was a risk they would not know when to discard it.

The records showed medicines were stock controlled monthly. When we compared some of the medicine in stock with the balance recorded in the medicine book we found some discrepancies. Two medicines were one tablet less than recorded in the balance. One missing tablet could not be explained and the second was due to a recording error by the electronic medicine administration system. One controlled medicine given in liquid form for pain relief was significantly incorrect and on the second day of our inspection the register manager confirmed that the actual liquid had been contaminated. Due to the wrong stock balance and the contamination of the medicine the registered manager had contacted the police, the safeguarding team, notified us and was starting an enquiry into what happened. The medication had last been recorded as given in September 2017, so the person the medicine was prescribed for had not been harmed by this recent medicine contamination.

The index at the front of the controlled medicines book was not always up to date. The index directed staff to the correct page in the book to view the current medicine balance which should be the same as the stock. However there were several entries where the index directed staff to one page when the actual balance was on another page. This inconsistent recording could be confusing for staff.

We recommend that the service consider current guidance on protocols relating to the administration of 'as required' medicines and the storage of medicines and take action to update their practice accordingly.

The temperature of the medicines fridge was monitored and we confirmed it remained in acceptable range. Medicines that were no longer required were disposed of safely.

Regular environmental and health and safety checks took place to ensure that the environment was safe and that equipment was fit for use. The building was appropriately maintained and some areas were being

redecorated. There were certificates to confirm the service complied with gas and electrical safety standards. Water temperatures were monitored to ensure people were not at risk of scalding. Appropriate measures were in place to safeguard people from the risk of fire.

Staff had been trained in fire safety awareness and first aid to be able to respond appropriately. Regular checks were carried out on the fire and smoke alarms to make sure they were working properly. However on the first day of inspection the fire door between the laundry and the office had been left propped open all morning with a heavy plastic container. This put people in the home at increased risk if there was a fire. Each person had a detailed personal emergency evacuation plan (PEEP), which set out the specific requirements needed to ensure they were safely evacuated from the service in the event of a fire. The evacuation plans needed to be simplified and placed in to one folder to ensure they could be easily used by the emergency services.

There was an up to date emergency procedure in place. This included details of how staff should manage different kinds of unforeseeable events. Plans were in place indicating where people would be accommodated if they were unable to return to the home after a fire. The provider had an out of hours on call system, which enabled serious incidents affecting people's care to be dealt with at any time. However the procedure required details on where staff could find the water and gas stop taps, to be added.

We found the home to be clean and tidy. The service employed a house keeper who was responsible for cleaning all communal areas and people's rooms. People were protected by the prevention and control of infection. Staff told us they had received training in the control of infection and food hygiene. We saw that staff had access to appropriate personal protective equipment [PPE] such as gloves and aprons to use when required. People told us "Oh yes, I think so, they clean pretty regularly" and "Clean enough? Oh yes thank you, yes."

Good

Is the service effective?

Our findings

People continued to receive care from staff who had the knowledge and skills to meet their needs. People and their relatives spoke well of staff, people's comments included; "Yes, they help you to do things, they chat things through" and "They say, do you need a bath and I say ok. You are never forced to do anything."

People's care needs were assessed to identify the support they required from staff. The assessment covered people's physical, mental health and social care preferences to enable the service to meet their diverse needs. These care plans contained clear instructions for staff to follow so that they understood how to meet individual care needs.

The Mental Capacity Act (MCA) 2005 provides a legal framework for acting and making decisions on behalf of people who lack the mental capacity to make specific decisions for themselves. We found the service continued to work within the principles of the MCA 2005. The registered manager had a good understanding of the MCA 2005 and staff had an understanding of how these principles applied to their role and the care they provided.

People had been also been assessed as having the capacity to understand and consent to agreeing the support and care they wanted from staff. This was recorded within their care plans. For example one person had to be offered a bath or shower, two or three times a week. This consent to care was periodically reviewed. Staff showed a good understanding of protecting people's rights to refuse care and support. Staff were clear where people had the mental capacity to make their own decisions, this would be respected. We saw the care records regularly reminding staff that they had to get the person's consent before they could provide care and support.

Staff training and the need to ensure it was kept up to date was covered both in staff meetings and supervision meetings. Staff confirmed their training was up to date. These included moving and handling, fire safety, safeguarding people and medicine administration. Staff told us that they were provided with regular supervision and felt well supported. One staff member said, "We regularly have supervision and training and feel able to say what I want." We saw records that showed staff received regular supervision and an annual appraisal. People said "Yes, they know what they're doing" and "Yes, they have the skills".

People were supported to have a meal of their choice by organised and attentive staff. They were asked where they wanted to sit to eat. People told us they were satisfied with the food and that there was plenty for them to eat. Within the care plans we saw there was guidance for staff relating to people's dietary needs and the help they needed from staff. People's comments included "The food is very good. What you want you have" and "The food is quite good. There are two choices and can have something else if you don't like what is available. Sometimes I would like a little more."

People continued to be supported by staff to use and access a wide variety of other services and social care professionals. We found there were regular visits including from people's GP, district nurse other relevant health care professionals. This helped to promote good communications resulting in consistent, timely and

coordinated care for people. We saw that input from other services and professionals was documented clearly in people's files, as well as any health and medical information. Every person said they were confident they would be able to see a doctor if they felt unwell. One person said "They are very hot on picking up on slight ailments; it is good that they notice."

We saw staff assisted people with their care and support and were responsive to people's individual needs. We found people's care records were person-centred. People's care records also informed the staff about the support they required and they detailed how people were encouraged to maintain their own independence. For example one person told us "I eat my meals in my room, they understand I prefer to eat in here."

People's diverse needs were met by the adaptation, design of the premises. There were adaptations within the premises like wooden rails along the corridors to reduce the risk of people falling and there was a lift within the premises for people who could not use the stairs. People's bedrooms were personalised with their belongings and were decorated according to their choice.

Good

Is the service caring?

Our findings

Staff had positive relationships with people. We found staff to be kind and friendly towards people. Staff took their time to talk with people and showed them that they were important. One person said, "Yes I am happy here" and another person said "Staff are nice, all a grand crowd, all very pleasant."

When staff spoke with people they were polite and courteous. Relatives were complimentary about how staff treated their family members. One relative said, "I've not one bad word to say about this home." One person told us "Oh yes they understand what I need, everybody knows."

People's privacy and dignity was respected and promoted. For example, staff knocked on bedroom doors before entering and addressed people by their preferred names. Care was provided to people in their bedrooms or in communal bathrooms with the doors closed. Staff were aware they must protect people's privacy and dignity at all times. Every person we spoke with thought that they were encouraged to be independent and were happy with this. One person said, "The staff always knock before they come in." We also observed this for ourselves.

Staff knew people well, including their preferences for care and their personal histories. When we asked about people, staff were able to describe peoples care needs and say how they preferred these to be delivered. We observed that staff knew where people preferred to sit and what objects were important to them and available. When help with personal care was needed, people told us they felt there dignity was maintained.

We observed staff supporting people in a friendly and kind way. Staff understood the importance of facing people when communicating. Staff walked alongside people at their own pace and gave verbal encouragement when needed. We spent time in communal areas and observed a calm and relaxed atmosphere. Staff told us that they tried to support people to maintain their independence as much as possible and assessed the level of support people needed all the time.

People were involved about making decisions relating to their care and support. One person said "They understand how I like to be looked after." People could have visitors whenever they wanted and there were no restrictions in place. Visitors told us "they are always welcoming and keep offering us drinks." We saw records of people's care reviews and it was evident that people and their family members had been involved and able to express their opinions about the care their relative received.

We carried out a specific type observation in one of the lounges of the home. We noted that staff interacted well with people, people were settled and content during this time and there were enough staff present to meet people's needs.

Good

Is the service responsive?

Our findings

The service responded to people's needs. People had a pre assessment completed before moving into the home. This covered a range of people's needs and helped staff plan their care and for them to get to know the person. Care plans were person centred and reflected people's individual needs and preferences. We saw that some of this information had also been provided by relatives.

Staff told us the information in care plans enabled them to provide care that met people's preferences. For example staff knew if a person preferred a cup of tea when they first got up or what time they liked to get up. We found one care record did not reflect a person's changing need. Bruises acquired during showering were being investigated but we did not find a body chart or a change in the care plan about the increased support the person would need when showering. The reason for this lack of response was explained to us and changes were going to be made as to which staff can fill in care records.

Overall, it was evident that staff understood people's individual needs and there were some clear examples of where staff had worked with families to ensure a person's needs were managed in the best way. We saw examples where best interest meetings and decisions had been taken with involvement from family members and the person's GP. One person told us "Care planning? Yes discussed. I am looked after as I would wish. Most of the staff understand I don't like too much fuss" and another said "Yes, I've got a sort of a plan of care. I contribute."

There were activities available for people to take part in if they chose to do so. People appeared to enjoy their own entertainment choices such as listening to music, watching their own television and reading. One person told us "I get a choice of activities, I choose not to take part, I like my radio" and another said "You can do quizzes, cross stitch – all sorts. Yes, I am happy my needs are met."

The activities taking place over the month were on display on notice boards around the home. The manager explained the strong links with the local community, including faith leaders visiting and that local schools visited regularly. One person said "Yes I can go out. I tend to get a taxi to the shops."

The provider had a clear system in place to manage complaints. Those received were investigated and responded to. Information about how to complain was provided to people in a suitable format. People told us they would raise issues with the registered manager or staff, and said issues were dealt with. One person said There are people I could go to, but I have no worries really" another said "Oh yes, I could speak to somebody. I've got a couple of people I could talk to but I've no need to."

End of life care for people was well managed. People's wishes had been discussed with them and recorded in a care plan. Details of relatives that should be contacted were also recorded in people's care plans.

Good

Is the service well-led?

Our findings

There was a registered manager in post who had made steady improvements within the home. The registered manager promoted a caring, positive, transparent and inclusive culture within the home. They actively sought feedback from people using the service, relatives, visiting health professionals and staff. One staff member said, "The management are brilliant. They step up and solve any problem we have." Another staff member said, "The manager is lovely, he's all about staff and residents being happy."

Staff spoke consistently about the service being a good place to work. They told us they felt supported, received regular supervision and had access to training opportunities. Staff also felt part of a team with the people using the service as their focus.

We were told that the registered manager was friendly and made themselves available if people wanted to speak with them. People felt they could approach the registered manager if they had any problems, and that they would listen to their concerns. The registered manager was often seen around the home and would stop to say hello and ask how people were as they passed by.

Systems were in place which continuously assessed and monitored the quality of the service. These included managing complaints, safeguarding concerns and incidents and accidents. The documentation showed that management took steps to learn from such events and put measures in place which meant they were less likely to happen again. Examples included where safeguarding matters had been investigated positive actions had been taken to keep people as safe as they could be.

We found the culture of the service to be positive and person-centred. There was a clear vision and set of values in place that included promoting involvement, compassion, dignity, independence and respect throughout the service. One person said "The manager is very good actually. I trust him explicitly" another said "All very pleasant here, not really needing improvement" and finally a comment which the person did not want to discuss further "You've got what you've got and have to put up with it."

People were asked for their feedback about the service in questionnaires and by the staff in general conversation. The manager explained that he spoke to everyone each day so that he could get people's views and deal with any problems that might have arisen. We looked at the results of the resident's survey, which was undertaken in June 2017. We found people were happy with the service provided. We saw the registered manager had an 'open door' policy in place; they were available to speak with anyone.

The registered manager and staff team worked in partnership with other agencies to support care provision so that people received joined-up care. For example, the GP visited on the first day of inspection and the district nurses on both days. Also there was a correspondence in people's care records from a range of healthcare professionals.

The provider has a legal duty to inform the CQC about certain changes or events that occur at the service. There are required timescales for making these notifications. We had received information about

notifications and we could see from the notifications appropriate actions had been taken.

Providers are required to comply with the duty of candour statutory requirement. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The regulation applies to registered persons when they are carrying on a regulated activity. We discussed the duty of candour requirement with the manager of the service. They told us they were knowledgeable about the requirement and the process.